

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05994

CERTIFICATE OF DEATH

05994

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Keedysville</b>		d. STREET ADDRESS <b>Rfd. 1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>George</b>	Middle <b>Wilbur</b>	Lost <b>Abbott Jr.</b>	4. DATE OF DEATH <b>April 15, 1966</b>	Month <b>April</b>	Day <b>15</b>	Year <b>1966</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 29, 1895</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR <b>9 Months</b>	IF UNDER 24 HRS. <b>16 Days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Brair, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George W. Abbott</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Norris</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>220-10-3958</b>		17. INFORMANT <b>Mrs. Clara Abbott, Keedysville Rfd. 1, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right hemiplegia</b>				INTERVAL BETWEEN DEATH AND DEATH <b>2 days</b>				
333x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral thrombosis</b>				DUE TO <b>2 days</b>				
(c) <b>Generalized arterosclerosis</b>				DUE TO <b>Year</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture 7 rib RT side</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Fell in L.S. Room</b>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>4 p.m. 3 - 31 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) <b>Boonsboro</b>	(County) <b>WASH</b>	(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>4-14-1966</b> to <b>4-15-1966</b> , that (I) (we) last saw the deceased alive on <b>3-14-1966</b> , and that death occurred at <b>8:15 AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>J. H. Secondari</b>				M.O. ATTENDING PHYS. <b>✓ MED. DIRECTOR</b>		STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4-15-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>				22d. ADDRESS <b>Boonsboro Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-18-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Rohrersville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rohrersville, Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10027

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

05995

05942

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)		
Washington MARYLAND		a. STATE	Maryland Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b	1 day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20 N. Artizan St.		
3. NAME OF DECEASED (Type or print) Bessie		First	Middle	
		Last		
4. DATE OF DEATH		Month	Day Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White	WIOOWEO <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.	
April 27 1890		75 yrs.	11 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Public School		
11. BIRTHPLACE (County & State, or foreign country) Conococheague Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ruben Wolford		14. MOTHER'S MAIDEN NAME Martha Brunner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 213 24 7688		
17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Due To (c) Due To				
Ruptured aortic aneurysm Arterosclerotic Cardiac Dis Hypertensive Cardiac Dis.				
INTERVAL BETWEEN ONSET AND DEATH Today year				
20a. ACCIDENT WAS UNDERRING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 16 Mar 1966, to date, 19 , that (I) (we) last saw the deceased alive on 20 Apr 1966, and that death occurred at 41 M, from the causes and on the date stated above.		22b. DATE SIGNED		
22c. SIGNATURE Richard T. Binford		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		22d. ADDRESS 1135 POTOMAC AVENUE HAGERSTOWN, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 23-6	23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery	23d. LOCATION (City, town or county) (State) Williamsport Maryland
24. FUNERAL DIRECTOR		AOORESS Albert I. Leaf Williamsport Md.		
25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

05996

**CERTIFICATE OF DEATH**

05993

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE	
WASHINGTON MARYLAND		MARYLAND WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
HAGERSTOWN		3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
WASHINGTON COUNTY HOSPITAL			
3. NAME OF DECEASED (Type or print)		First	Middle
WALTER ELIJAH		BAKER	4. DATE OF DEATH APRIL 13 1966
Last		Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
MALE		WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
RETIRED BOILERMAKER		RAIIROAD	
13. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)	
ELIJAH E. BAKER		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		705-10-7430	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
MRS. JACK GRAY		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anute myocardial infarction</i> <i>4201</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>coronary sclerosis</i> (c) <i>Atherosclerotic Cardiv Dis.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Abd. Aneurysm, Nephrosclerosis - Aspirating gastritis</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1 apr 1966</i> , to <i>date</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12 apr 1966</i> , and that death occurred at <i>2A M</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>4/14/1966</i>	
22a. SIGNATURE <i>Richard T. Binford</i>		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>RICHARD T. BINFORD M.D.</i> <i>1135 POTOMAC AVE. HAGERSTOWN, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>APRIL 15, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>ROSE HILL CEMETERY</i>		23d. LOCATION (City, town or county) (State) <i>HAGERSTOWN, MARYLAND</i>	
24. FUNERAL DIRECTOR <i>Charles J. Langer</i>		25a. REC'D BY REGISTRAR ADDRESS <i>HAGERSTOWN, MARYLAND</i>	
		25b. REGISTRAR'S SIGNATURE DATE <i>APR 18 1966</i> <i>Charles J. Langer</i>	

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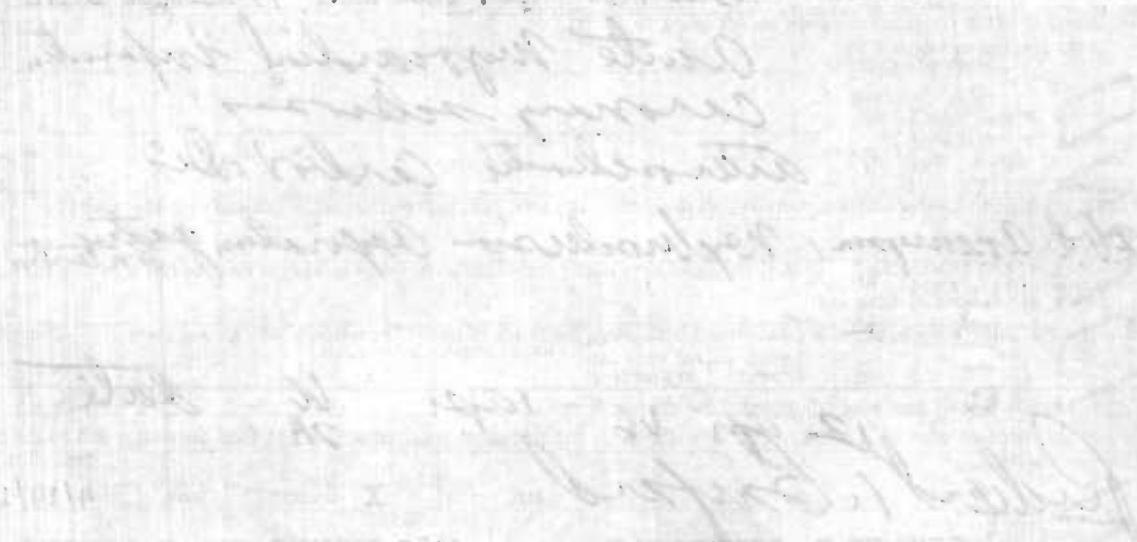
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												05997		05994							
CERTIFICATE OF DEATH																					
1. PLACE OF DEATH a. COUNTY <b>Washington</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>18 days</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Washington</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring, Md.</b>				d. STREET ADDRESS <b>Mill St.</b>									
3. NAME OF DECEASED (Type or print) <b>Isabel Margaret Bell</b>				First		Middle		Last		4. DATE OF DEATH <b>April</b>		Month		Day		Year					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1892</b>		9. AGE (In years last birthday) <b>73 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>House work</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Phila. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Grant St. Pierre McEnany</b>				14. MOTHER'S MAIDEN NAME <b>Isabel Baker</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Albert M. Bell</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, acute and Hepatic Failure</b>												INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>									
1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) <b>Carcinomatosis, generalized</b>				unknown													
				DUE TO (c) <b>Adenocarcinoma of the colon</b>				7 years													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Anemia, due to carcinomatosis</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED <b>May 1959</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Clear Spring, Md.</b>		20f. (City or town) <b>Clear Spring, Md.</b>		(County) <b>Howard Co.</b>		(State) <b>Md.</b>	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>May 1959</b> , 1959, April 9, 1966, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>April 19, 1966</b> , and that death occurred at <b>8:55 PM</b> , from the causes and on the date stated above.												22a. SIGNATURE <b>Archie Robert Cohen</b>				22b. DATE SIGNED <b>04/11/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>				22d. ADDRESS <b>Clear Spring, Maryland</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/12/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Peters Luthern</b>		23d. LOCATION (City, town or county) <b>Clear Spring, Md.</b>		(State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Charles Judge</b>								25a. REC'D BY REGISTRAR <b>Charles Judge</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									
VR A15 (4) 15M 4-64																					



FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>D. O. A.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg Md.</b> d. STREET ADDRESS <b>Mechanic St.</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Robert Lynwood Benner</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
5. SEX <b>Male</b> <b>White</b>		6. COLOR OR RACE <b>WIOOWED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11 1912</b>	9. AGE (in years last birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR <input type="checkbox"/> Months <b>5</b>	IF UNDER 24 HRS. <input type="checkbox"/> Days <b>8</b>	Hours <b>0</b>	Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>				11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Luther Benner</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Lapole</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Mr. Frederick L. Price</b> Address <b>Gaithersburg Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver</b> 5811 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. (b) <b>chronic alcoholism</b> (c) DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20-30 yrs. INTERVAL BETWEEN ONSET AND DEATH One week													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. TIME OF INJURY Month, Day, Year Hour a.m. <b>White</b> Not White p.m. <b>at work</b> <input type="checkbox"/> at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>20g. (County)</b> <b>(State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Howard N. Weeks</i> EXAMINER'S NAME (Type) <b>Howard N. Weeks, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/20/66 Address (Street, city, town, or county) <b>580 Northern Ave.</b> <b>Hagerstown, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>April 24-66</b>				23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. View Cemetery</b>				23d. LOCATION (City, town or county) <b>Sharpsburg Md.</b> (State)					
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>				25a. REC'D BY REGISTRAR <b>APR 25 1966</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

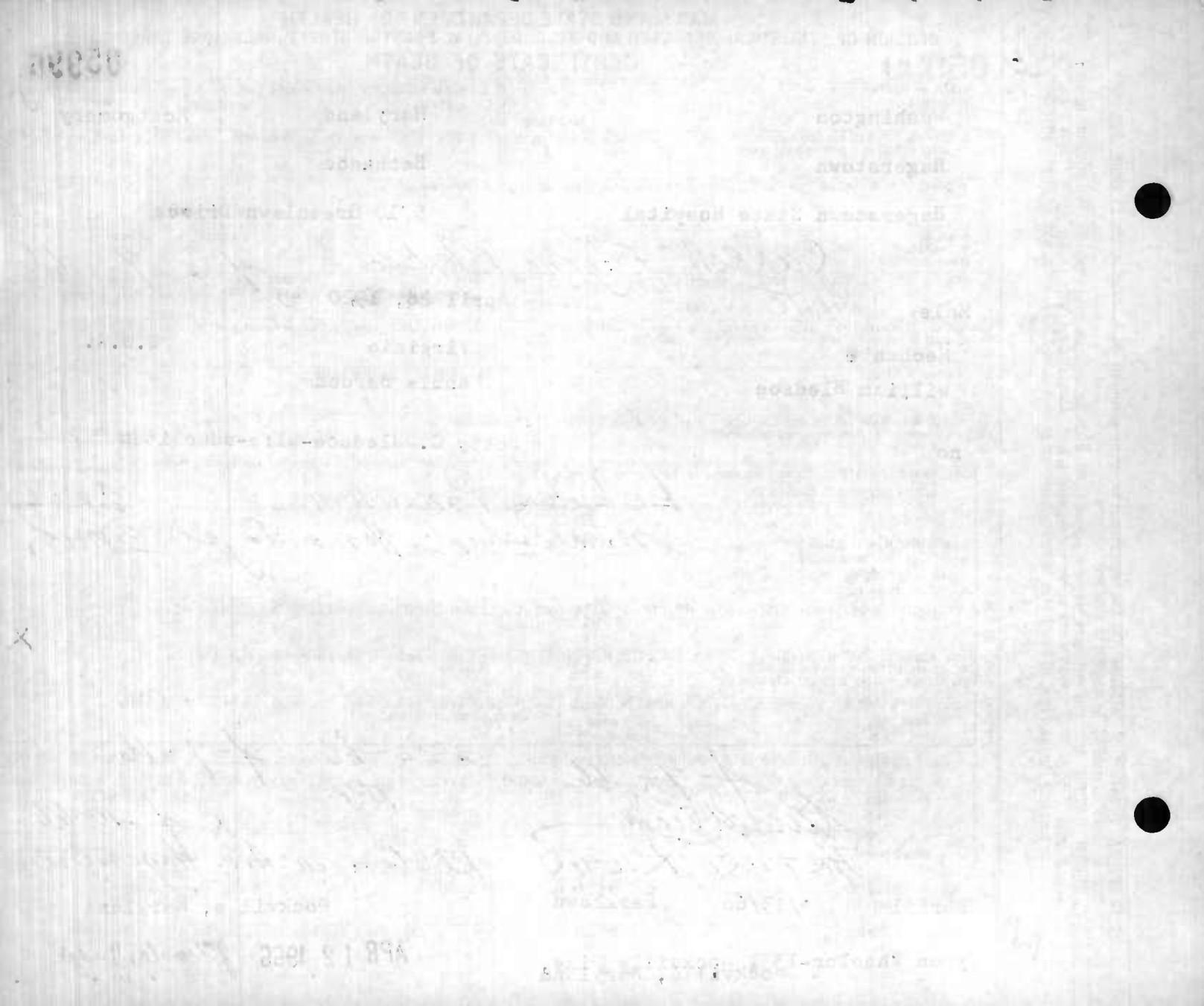
**CERTIFICATE OF DEATH**

05996

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05996		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
a. COUNTY Washington MARYLAND		a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hagerstown State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
3. NAME OF DECEASED (Type or print) <i>Carroll Eugene Bledsoe</i>		d. STREET ADDRESS 5710 Greenlawn Drive	
4. DATE OF DEATH J - 9 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male white		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1920	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bledsoe		14. MOTHER'S MAIDEN NAME Annie Barden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no		16. SOCIAL SECURITY NO.	
		17. INFORMANT Betty C. Bledsoe-wife-same item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>Lobular Pneumonia</i> <i>Intracerebral Hemorrhage</i> 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-22-1966</i> , to <i>J-7-1966</i> , that (I) (we) last saw the deceased alive on <i>4-7-1966</i> , and that death occurred at <i>15 M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>David L. Riego</i>		22b. DATE SIGNED <i>4-10-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>ARTURO RIEGO</i>		22d. ADDRESS <i>1500 Penna. Ave. Hagerstown</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/13/66	
23c. NAME OF CEMETERY OR CREMATORIUM Parklawn		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler-1331 Rockville Pike, Rockville, Maryland		25a. REC'D BY REGISTRAR APR 12 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15397							
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY <b>Washington</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Pool, Md.</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Washington</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Pool, Md.</b>				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural Residence</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Elizabeth</b>		Middle <b>Zeller</b>		Last <b>Russell</b>		4. DATE OF DEATH <b>April 21 1966</b>		Month <b>April</b>		Day <b>21</b>		Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 22, 1890</b>		9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDERR 1 YEAR Months <b>0</b>		11. IF UNDER 24 HRS Days <b>0</b>		12. IF UNDER 24 HRS Hours <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home duties</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Oakland W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Nathan Howard Bohrer</b>				14. MOTHER'S MAIDEN NAME <b>Emma Spielman Zeiler</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-16-0289</b>				17. INFDRMNT <b>Edwin Bohrer</b> <b>Big Pool, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b>												5 minutes							
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery Occlusion with Myocardial Infarction</b>												20 minut							
DUE TO (c) <b>Hypertensive Heart Disease</b>												unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>Nov 7, 1962</b>		(County) <b>to April 21 1966</b>		(State)			
21. I certify that (I) (this hospital) attended the deceased from April 18 1966, and that death occurred at 6:35 PM, saw the deceased alive on April 18 1966, and that death occurred at 6:35 PM, from the causes and on the date stated above.												22b. DATE SIGNED <b>04/22/66</b>							
22a. SIGNATURE <i>Archie Robert Cohen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>04/22/66</b>							
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>				22d. ADDRESS <b>Clear Spring, Maryland</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/24/66</b>				23c. NAME OF CEMETERY OR CREMATORIUM <b>Oakland W. Va. Church Oakland</b>				23d. LOCATION (City, town or county) <b>Clear Spring, Maryland</b>				(State) <b>W. Va.</b>			
24. FUNERAL DIRECTOR <i>Margaux Rowland</i>				ADDRESS <b>Clear Spring, Md.</b>								25a. REC'D BY REGISTRAR <b>APR 26 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												05998		
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				b. COUNTY						
Washington MARYLAND				Maryland Washington										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Hagerstown				2 days				Hagerstown				21-1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?						
Washington County Hospital				2707 Virginia Avenue				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)				Last				4. DATE OF DEATH				Day Year		
IRVIS First A. HOLMES				Bowen				April				27 1966		
Alias) Willard Howard														
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		April 25 1894		72 yrs.		Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?		
Bookkeeper				Tax Service				Virginia				U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME										
James N. Holmes				Pheada (Unknown)										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address		
YES				World War I				2707 Va. Ave.				Mrs. Mabel H. Bowen Hagerstown Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												i-2 mo		
15+X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)												Adenocarcinoma, rectal		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												4 mo+		
Glaucoma														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 3-25, 1958 to death, 1966, that (I) (we) last saw the deceased alive on 4-27 1966, and that death occurred at 1:25 P.M. from the causes and on the date stated above.												22b. DATE SIGNED		
22a. SIGNATURE Robert F. Keable												M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	4-27-66	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS								Hagerstown Md		
Burial				Memorial East Lawn Gardens								Harrisonburg Va.		
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City, town or county) (State)		
Burial				April 29-66										
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
Albert L. Leaf Williamsport, Maryland								DATE APR 29 1966				Charles Judge		

Intake  
metabolism

metabolic feedback

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06002

## CERTIFICATE OF DEATH

05991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>4 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert Lee</b>		First <b>Bowers</b>	Middle <b>Albert</b>
4. DATE OF DEATH <b>April 6,</b>	Month <b>April</b>	Day <b>6</b>	Year <b>1966</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13. FATHER'S NAME <b>George Bowers</b>		14. MOTHER'S MAIDEN NAME <b>Susan Baker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Nellie S. Bowers</b>		Address <b>Rfd. 1, Middletown Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> 446 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Nephrosclerosis 5 years (c) DUE TO GENERALIZED ARTERIOSCLEROSIS 20 "		INTERVAL BETWEEN ONSET AND DEATH <b>1 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gangrene, ARTERIOSCLEROTIC left leg</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7A M.</b>
20f. (City or town) <b>7A M.</b>		(County) <b>Wash.</b>	
(State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>April 2, 1966</b> , to <b>April 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1966</b> and that death occurred at <b>7A M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>4/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. MORAN</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> <b>JOHN A. MORAN M.D.</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>215 W. Washington St. Hagerstown, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-8-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Benevola E. U. B. Cemetery</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr.</b>		ADDRESS <b>112 N. Main St. Boonsboro, Md.</b>	25a. REC'D BY REGISTRAR <b>APR 11 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 1 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HANCOCK</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VIRGINIA AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS <b>VIRGINIA AVENUE</b>	
3. NAME OF DECEASED (Type or print) <b>LLOYD WILLIAM BRAKEALL</b>		First <b>L</b>	Middle <b>WILLIAM</b>
4. DATE OF DEATH <b>APRIL 1 1966</b>	Month <b>APRIL</b>	Doy <b>1</b>	Year <b>1966</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/1898</b>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B&amp;O RAILROAD EMPLOYEE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>HENRY CLAYTON BRAKEALL</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE RICE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W. 1</b>	17. INFORMANT <b>CLARA E. BRAKEALL, VIRGINIA AVE.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address <b>HANCOCK, MD.</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 min.</b>	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease</b>		15 yrs	
DUE TO (c) <b>Arteriosclerosis</b>		15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>12/3</b> , 1963, to <b>3/26</b> , 1966, that (I) (we) last saw the deceased alive on <b>3/26/66</b> 19
20f. (City or town) <b>HANCOCK</b> (County) <b>MARYLAND</b> (State) <b>MD</b>		21. I certify that (I) (this hospital) attended the deceased from <b>12/3</b> , 1963, to <b>3/26</b> , 1966, that (I) (we) last saw the deceased alive on <b>3/26/66</b> 19, and that death occurred at <b>HANCOCK</b> M, fram causes and on the date stated above.	
22a. SIGNATURE <b>F B Thomas III M.D.</b>		22b. DATE SIGNED <b>APR 6 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK B. THOMAS 111</b>		22d. ADDRESS <b>Hancock, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/4/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>ST. THOMAS EPICOPAL</b>
24. FUNERAL DIRECTOR <b>Howard &amp; Sonne Hancock Md</b>		25a. REC'D BY REGISTRAR <b>APR 6 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

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第6章第11页/共22

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#### REFERENCES AND NOTES

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2. *Trichopteridae* (continued) 3. *Chrysopidae*

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then close, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

06004		06004	
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERS TOWN, MD</b>		c. LENGTH OF STAY IN 1b <b>2 Mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>		e. STREET ADDRESS <b>KENTLAND, MD.</b>	
3. NAME OF DECEASED (Type or print) <b>Mario Hilda BREWER</b>		First	Middle
4. DATE OF DEATH <b>April 30, 1966</b>		Last	Month Day Year
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <b>Oct. 30, 1896</b>		9. AGE (in years last birthday) <b>69 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>STEUVEN FOX</b>		14. MOTHER'S MAIDEN NAME <b>UNK.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>DOROTHY E. BREWER</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>arteriosclerosis, general</b> DUE TO (c)		Address <b>7646 GOODLAND DR KENTLAND, MD.</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>is chronic brain syndrome</b>		unknown	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Western Md. State Hospital Hagerstown, md.</b>
20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from <b>April 11, 1966</b> , to <b>April 30, 1966</b> , that (I) was last saw the deceased alive on <b>April 30, 1966</b> , and that death occurred at <b>1:59 P.M.</b> from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> ND <input checked="" type="checkbox"/>	
22a. SIGNATURE <b>VICTOR L. RAMOS, m.d.</b>		22b. DATE SIGNED <b>April 30, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, m.d.</b>		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>Western Md. State Hospital Hagerstown, md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 3 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>MEADOWRIDGE CEM. RIVERDALE, MD.</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS Co.</b>		23d. LOCATION (City, town or county) (State) <b>ELKRIDGE, MD.</b>	
25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**M**

06005

## CERTIFICATE OF DEATH

060052

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>40 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>65½ West Franklin St.</b>				d. STREET ADDRESS <b>65½ West Franklin St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Charles</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 18,</b>	Month	Doy Year <b>19 66</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 20, 1916</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR <b>1</b> Months	IF UNDER 24 HRS. <b>28</b> Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			11b. KIND OF BUSINESS OR INDUSTRY <b>Cleaning</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Zittlestown, Md.</b>		
13. FATHER'S NAME <b>Fred Brown</b>				14. MOTHER'S MAIDEN NAME <b>Zelle Poffenberger</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>215-18-2424</b>		17. INFORMANT <b>Mrs. Mary E. Brown, 65½ W. Franklin St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>4201</b>				<b>Coronary Thrombosis</b>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) (c)				<b>Cystic - Sclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Diabetes Mellitus - 7 yrs.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boonsboro Cemetery</b>		20f. (City or town) (County) (State) <b>Boonsboro, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1966</b> , to <b>April 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 18, 1966</b> , and that death occurred at <b>Boonsboro, Md.</b> from causes and on the date stated above.				22b. DATE SIGNED <b>4/19/66</b>			
22a. SIGNATURE <b>J.H. Beachy</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>J.H. Beachy</b>		22d. ADDRESS <b>Boonsboro, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-21-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Boonsboro Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>APR 21 1966</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. at Health prior to a burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 4 Film G375 4/20/66 mh

**CERTIFICATE OF DEATH**

**06006** **06006**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALEM AVE.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>			d. STREET ADDRESS <b>HAGERSTOWN MD.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <b>MARY</b>	Middle <b>CHRISTINA</b>	Lost	4. DATE OF DEATH <b>April 10, 1966</b>	Month Day Year
S. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12.25.1915</b>	9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10. DO. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>FULTON COUNTY PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HARRY BARNHART</b>			14. MOTHER'S MAIDEN NAME <b>BESSIE SEAL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ROY L FUNKHOUSER 26 HOFFMAN DRIVE WILLIAMSPORT MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5810</b> <i>Cerebral Edema</i> DUE TO <b>Septicemia Com a Portal Cerebro</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9/4 1965 to 3/1 1966</b>		20f. (City or town) <b>3/1 1966</b> (County) <b>MD.</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/4 1965</b> to <b>3/1 1966</b> , that (I) (we) last saw the deceased alive on <b>3/1 1965</b> , and that death occurred on <b>3/1 1966</b> M, from causes and on the date stated above.						
22. SIGNATURE <b>Donald E. Martin</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <b>4/12/66</b>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Donald E. Martin M.D. 418 North Potomac St. Hagerstown, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4.14.66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>ORCHARD RIDGE CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>RURAL HANCOCK WASHINGTON MD.</b>
24. FUNERAL DIRECTOR <b>Howard &amp; Son Hagerstown</b>				25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

6/10/63

2000 ft

DRY VALLEY

OTONTO

500' DEEP

VALLEY

WATERFALLS

TOPSOIL

174000 YARDS WOKEHARAP

115000 CUBIC YARDS

2101.25.01

231192.00 N

3500' DEEP BY 1000' WIDE BY 100' HIGH

March 3 buried  
in soil without  
soil being disturbed

11 1/2 x 22 x 1/2  
15/4 X 11 1/2 x 11 1/2  
without 3 secured

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G375 4/15/66 mh

## CERTIFICATE OF DEATH

Reg. Dist. No.

06004

06007



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death; Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
79					
3. NAME OF DECEASED (Type or print)	First HERBERT	Middle W.	Last BRY AN		
4. DATE OF DEATH	Apr. 1, 1966		Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/23/07 1907		
8. AGE (In years last birthday) yrs. 59	9. IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	10b. KIND OF BUSINESS OR INDUSTRY Grading & Excav.	11. BIRTHPLACE (State or foreign country) Mercersburg, Pa. R.D.	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Alonza A. Bryna		14. MOTHER'S MAIDEN NAME Mabel Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-2968		17. INFORMANT Mrs. H.W. Bryan Address 800 Dual Highway Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Hypertension		acute onset			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO Arteriosclerotic Heart Disease		7 yrs			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Diabetes mellitus 14 yrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 21, 1966, to April 1, 1966, that I last saw the deceased alive on 3/21, 1966, and that death occurred at 7:30 a.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edson B. Moody, M.D.		145 S. Prospect St., Hagerstown, Md.			
PHYSICIAN'S NAME (Type) Edson B. Moody, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/66		22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cem.	
22d. LOCATION (City, town, or county) Mercersburg, Pa.					
23. FUNERAL DIRECTOR'S SIGNATURE Title Brininger		ADDRESS Mercersburg, Pa.		24a. REC'D BY REGISTRAR APR 12 1966	
				24b. REGISTRAR'S SIGNATURE Charles Judge	

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## CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
WILLIAM HENRY COOPER	65	M	CHRONIC CARDIOPNEUMONIC HEART DISEASE
ADDRESS	STREET	CITY	STATE
100 W. 10TH ST.	10TH	KAN CITY	MO
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR	NAME AND ADDRESS OF CEMETERY	
DR. JAMES L. COOPER 100 W. 10TH ST. KAN CITY, MO.	COOPER FUNERAL HOME 100 W. 10TH ST. KAN CITY, MO.	WILSON CEMETERY KAN CITY, MO.	
TIME OF DEATH	DATE OF DEATH	TIME OF BURIAL	DATE OF BURIAL
10:00 A.M.	NOVEMBER 12, 1968	10:00 A.M.	NOVEMBER 12, 1968
NAME OF PERSON SIGNING	RELATIONSHIP	ADDRESS	PHONE NUMBER
JOHN COOPER	SPOUSE	100 W. 10TH ST. KAN CITY, MO.	321-1234

FOR STATE  
HEALTH DEPT.

Item 18 Film G376 4/ MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06008

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06005

1. PLACE OF DEATH  
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits,  
write RURAL and give nearest town)

Harrisburg

c. LENGTH OF STAY IN 16

D. O. A

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF  
DECEASED  
(Type or Print)

First  
Leo

Middle  
Dewey

Last  
Burk

4. DATE  
OF  
DEATH  
April

Month  
15  
Day  
Year  
1966

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

June 28 1898

9. AGE (in years  
last birthday)

67 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William R. Burk

14. MOTHER'S MAIDEN NAME

Emma Jane Noravia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

214 03 632

17. INFORMANT

Mrs. Mary Burk

Address  
120 S. Artisan St.

Williamsport, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,  
IMMEDIATE CAUSE (a)

4201

Pending Thrombotic occlusion of

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO anterior descending left coronary artery

(b) Myocardial infarction, old

DUE TO

(c) Coronary atherosclerosis, severe

INTERVAL BETWEEN  
ONSET AND DEATH  
instant

sev. yrs.

2  
MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.

20d. INJURY OCCURRED  
While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

E. W. DITTO, JR., M. D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4-18-66

Address (Street, city, town, or county) 215 W. Washington St.

(State)

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

Riverview Cemetery Williamsport, Md.

(State)

23. FUNERAL DIRECTOR

ADDRESS

24e. REC'D BY REGISTRAR

APR 19 1966

24b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

2001.01.20

1 M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

06009 06006

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
Washington MARYLAND		a. STATE Maryland	b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		
Hagerstown		40 yrs.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM?		
846 Maryland Ave.		846 Maryland Ave.		
f. NAME OF DECEASED (Type or print)		First	Middle	
Clara		Edith	Byrem	
g. SEX		h. COLOR OR RACE	i. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
j. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		k. 10b. KIND OF BUSINESS OR INDUSTRY		
Housewife		Own Home		
l. 13. FATHER'S NAME		m. 14. MOTHER'S MAIDEN NAME		
Joseph Rowe		Rebecca Ambrose		
n. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		o. 16. SOCIAL SECURITY NO.		
No		None		
p. 17. INFORMANT		Address		
Mr. J.H. Byrem		846 Md. Ave. Hagerstown, Md.		
q. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4501 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				
gouty eye of both lower extremities arteriosclerotic disease				
INTERVAL BETWEEN ONSET AND DEATH 2-3 days Year				
r. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
s. MEDICAL CERTIFICATION		t. 20a. ACCIDENT WAS UNDERLYING DR CNDNTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <i>slip &amp; fall</i>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19				
21. I certify that (I) (this hospital) attended the deceased from 1956, 19, to 4/26/66 19, that (I) (we) last saw the deceased alive on 4/25/66 19, and that death occurred at M, from the causes and on the date stated above.				22b. DATE SIGNED 4/29/66
22a. SIGNATURE <i>Howard N. Weeks, M.D.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 580 Northern Ave. Hagerstown, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/66	23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR <i>W.C. Hornet</i>		ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.	25a. REC'D BY REGISTRAR MAY 2 1966	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

400 C 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>70 YRS.</b>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First <b>JOSEPHINE</b>	Middle <b>OR INDIA</b>	Last <b>CAMPBELL</b>	4. DATE OF DEATH <b>APRIL 27 1966</b>	Month <b>APRIL</b>	Day <b>27</b>	Year <b>1966</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/2/1874</b>	9. AGE (in years last birthday) <b>91 yrs.</b>	10. IF UNDER 1 YEAR Months <b>91</b>	11. IF UNDER 24 HRS. Days <b>hrs.</b>	12. IF UNDER 24 HRS. Hours <b>17 hrs.</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>THOMAS B. RINGER</b>				14. MOTHER'S MAIDEN NAME <b>ALICE DERR</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>257-36-8316</b>			17. INFDRMAN <b>MR. LEWIS D. RINGER</b>			Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> INTERVAL BETWEEN ONSET AND DEATH <i>17 hrs.</i>												
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) <i>Coronary thrombosis</i>						<i>17 hrs.</i>			
			DUE TO (c) <i>Arteriosclerotic Heart Disease</i>						<i>2 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1953</b> , to <b>APRIL 27, 1966</b> , that (II) (we) last saw the deceased alive on <b>APRIL 27 1966</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.												
22a. SIGNATURE <i>Loyd A. Hoffman</i>												
22b. DATE SIGNED <i>4/28/66</i>												
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS <i>214 N. Potomac St.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/30/66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>ROSE HILL CEM.</b>			23d. LOCATION (City, town or county) <b>HAGERSTOWN</b>			(State) <b>MD.</b>		
24. FUNERAL DIRECTOR <i>W. J. Marment, Hagerstown, Md.</i>			ADDRESS			25a. REC'D BY REGISTRAR <b>DA MAY 3 1966</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TOOK  
STANLEY STADLER  
MURKIN  
HORNIG  
14. BOSTON OSS  
JULY 10 1940  
SUSPENDED  
T P RUMSEY X BETTER MAN  
CHARLES DUNN  
HORNIG 25512  
PROBLEMS  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06011

## CERTIFICATE OF DEATH

06008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>2 weeks</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Route 2</b>	
3. NAME OF DECEASED (Type or print) <b>First</b> <b>Oliver Trenton Campbell</b>		Last <b>Month</b> <b>April 24</b>	
4. DATE OF DEATH <b>Year</b> <b>1966</b>		Month <b>Day</b> <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 30, 1888</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>LuRay, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George W. Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jenkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Urinary</b>			
446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Cerebral Hemorrhage &amp; congestive failure</b>			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>19</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1966</b> , to <b>April 24, 1966</b> that (I) (we) last saw the deceased alive on <b>April 23, 1966</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>M. E. Byrkit, M. D.</b>		22b. DATE SIGNED <b>4.25.66</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit, M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <b>Williamsport Maryland 21795</b>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4.27.66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>STONE BRIDGE BRETHERN RURAL HANCOCK WASHINGTON M</b>		23d. LOCATION (City, town or county) (State) <b>MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Stone Hancock MD</b>				ADDRESS			
				25a. REC'D BY REGISTRAR <b>APR 29 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06012

## CERTIFICATE OF DEATH

06009

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if absent, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>4 1/2 Wks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>153 Dogwood Dr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BEATRICE NAOMI CLEVER</b>		First <b>BEATRICE</b>	Middle <b>NAOMI</b>
4. DATE OF DEATH <b>April 6, 1966</b>	Last <b>CLEVER</b>	Month <b>April</b>	Day Year <b>6, 1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Feb. 5, 1917</b>	9. AGE (In years last birthday) <b>49 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
10c. FATHER'S NAME <b>John Heckman</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Wash. City</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. MOTHER'S MAIDEN NAME <b>Marjorie Daley</b>	14. INFIRMITY <b>Harry D. Clever, 153 Dogwood Dr Hagerstown, Md.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. Address <b>Address</b>	INTERVAL BETWEEN DEATH AND DEATH <b>48 hours</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral lobular pneumonia + Emphysema</b>			
DUE TO (b) <b>Gastro-esophageal anastomosis</b>			
DUE TO (c) <b></b>			
1 week -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic bronchitis + granulocytopenia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b></b>
20f. (City or town) <b></b>		(County) <b></b>	
		(State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/3, 1966</b> , to <b>4-6, 1966</b> , that (I) (we) last saw the deceased alive on <b>4-6, 1966</b> , and that death occurred at <b>10:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John St. John Baker</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>4-7-66</b>
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>
24. FUNERAL DIRECTOR <b>A. K. Coffman Funeral Home, Inc.</b>		ADDRESS <b>Hagerstown, Md.</b>	25a. REC'D BY REGISTRAR <b>APR 11 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**06013**

**CERTIFICATE OF DEATH**

**116010**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE							
WASHINGTON MARYLAND		MARYLAND WASHINGTON							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
HAGERSTOWN	7 HRS	WILLIAMS PORT RURAL							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)									
WASHINGTON COUNTY HOSPITAL									
3. NAME OF DECEASED (Type or print)	First GARY	Middle WAYNE	Last COMMER	4. DATE OF DEATH	Month APRIL	Day 16	Year 1966		
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
MALE	WHITE	WIDOWED	DIVORCED	APRIL 15, 1966	yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
NONE		-----		WASHINGTON CO., MARYLAND		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
EUGENE COMMER				MARLENE E. BELLOMO					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT	Address					
NO	NONE		MR. EUGENE COMMER R.D.# 2 WILLIAMS PORT, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
7625 Premature of old diseases									
Cconditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.									
DUE TO (b) Immediate									
DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH 7 hrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from 16 April 1966, to 17 April 1966, that (I) (we) last saw the deceased alive on 17 April 1966, and that death occurred at 12:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Harold H. Gist				22b. DATE SIGNED 4/18/1966					
22c. PHYSICIAN'S NAME (Type) HAROLD H. GIST M.D.				22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD.					

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county) (State)	
BURIAL	4/18/1966	ROSE HILL CEMETERY	HAGERSTOWN, MARYLAND	
24. FUNERAL DIRECTOR	ADDRESS			
Hagerstown, Maryland			25a. REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
			APR 20 1966	Charles Judge

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06014

## CERTIFICATE OF DEATH

06011

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>111 E. Baltimore St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>111 E. Baltimore St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY</b>		First <b>PRESTON</b>	Middle <b>CRUNKLETON</b>
4. DATE OF DEATH <b>Sept. 27, 1902</b>		Month <b>April</b>	Year <b>1966</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 27, 1902</b>		9. AGE (In years last birthday) <b>63 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>branch mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Greencastle, Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry S. Crunkleton</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca J. Pensinger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-0734</b>	
17. INFORMANT <b>Mrs. Virginia Crunkleton, Hag., Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1550</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>testes</b>		<b>Liver cell carcinoma is generalized</b> <b>8 mos</b>	
(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>108 M.</b>
20f. (City or town) <b>108 M.</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 12, 1966</b> , to <b>Sept. 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>Aug 23, 1966</b> , and that death occurred at <b>108 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b>		22b. DATE SIGNED <b>4-30-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III. M.D.</b>		22d. ADDRESS <b>217 West Washington Street Hag., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5-2-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Rest Haven Cemetery</b>
23d. LOCATION (City or Town) <b>Hagerstown, Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>D MAY 4 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

1033

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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06015

## CERTIFICATE OF DEATH

06012

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 4 should be filed with the State Dept. of Health after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>3 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Martin Manor Nursing Home</b>		d. STREET ADDRESS <b>427 W. Franklin St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>IDA BESSIE CUNNING</b>		First <b>IDA</b>	Middle <b>BESSIE</b>
4. DATE OF DEATH <b>April 6 1966</b>	Month <b>April</b>	Day <b>6</b>	Year <b>1966</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>Feb. 10, 1877</b>	9. AGE (In years lost birthday) <b>89 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Md. Hagerstown, Wash. Cty U.S.A</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Jacob Miller</b>	14. MOTHER'S MAIDEN NAME <b>no Record</b>	17. INFORMANT <b>William Riley, R # 3, Hagerstown, Md</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	Address <b>Sharpsburg Pike</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X Bilateral cellular pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <b>lost.</b>		(b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arterio sclerosis, generalized</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 22, 1966</b> , to <b>Apr 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>Mar 26, 1966</b> , and that death occurred at <b>Hagerstown, Md.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>4-7-66</b>	
22a. SIGNATURE <b>Edward W. Ditto III, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		22d. ADDRESS <b>217 West Washington St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/9/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md. Wash. Ct.</b>
24. FUNERAL DIRECTOR <b>A. K. Coffman Funeral Home, Inc.</b> Hagerstown, Md.	25a. REC'D BY REGISTRAR <b>APR 11 1966</b>		
	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

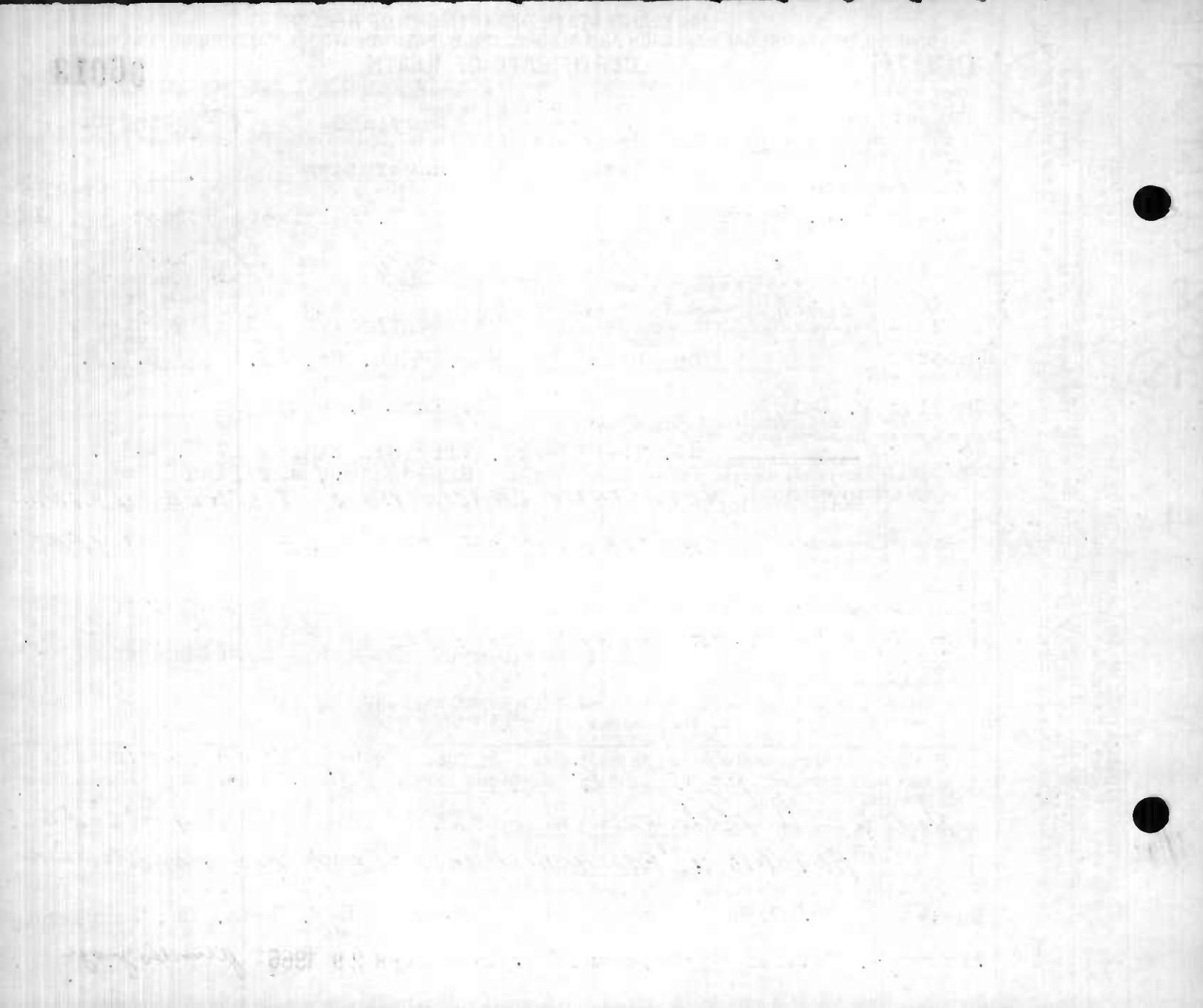
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06017

## CERTIFICATE OF DEATH

16014

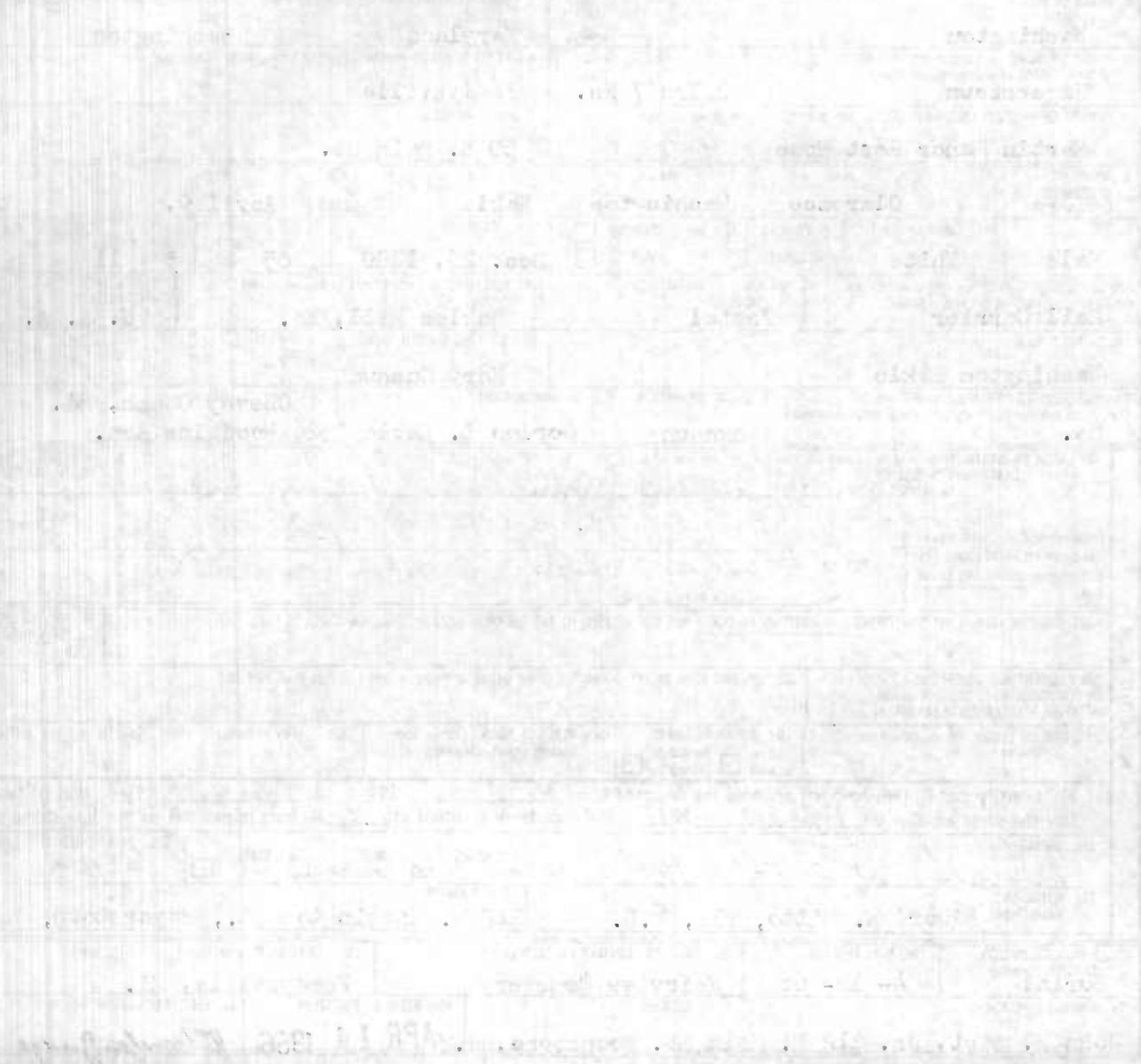
**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**PAGE 4** may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>2 Yrs 7 Mo.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b>		d. STREET ADDRESS <b>50 S. Main St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Martin Manor Rest Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Clarence</b>	Middle <b>Washington</b>	Last <b>Eakle</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1880</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Postal</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Eakles Mill, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Washington Eakle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cushwa</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Gordon L. Eakle 3526 Woodbine Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Cerebral Thrombosis - due to advanced general arteriosclerosis - and</b> DUE TO <b>② Adeno Carcinoma prostate &amp; general metastasis.</b> INTERVAL BETWEEN ONSET AND DEATH <b>10-15 yr</b> 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1965</b> , to <b>Apr 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>17 Mar 9 1966</b> , and that death occurred at <b>1040</b> M, fram causes and on the date stated above.		22b. DATE SIGNED <b>4-11-66</b>	
22a. SIGNATURE <b>Edward W. Ditto III</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS <b>217 W. Washington St., Hagerstown, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4- 12- 66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview Cemetery</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		ADDRESS <b>DA</b>	25a. REC'D BY REGISTRAR <b>APR 14 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

A1007

11/19/01



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

06018

## CERTIFICATE OF DEATH

06015

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HANCOCK</b>		c. LENGTH OF STAY IN 1b <b>35 YEARS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HANCOCK</b>		d. STREET ADDRESS <b>W. MAIN STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOME, MAIN STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>FLOYD</b>	Middle <b>WALLACE</b>	Last <b>EDMONDS</b>	4. DATE OF DEATH <b>APRIL 1, 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/26/1905</b>	9. AGE (In years last birthday) <b>60 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATE ROADS: EQUIPMENT OPERATOR</b>			11. BIRTHPLACE (County & State, or foreign country) <b>NORTH DAKOTA</b>			
13. FATHER'S NAME <b>NOR AVAILABLE</b>			14. MOTHER'S MAIDEN NAME <b>JOSEPHINE RICHARDS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>JAMES W. MC LEAN KOLORAMA AVENUE</b> Address <b>SYKESVILLE, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> DUE TO <b>ASHD</b> 5 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>if 4/60</b>	20f. (City or town) <b>21st</b>	(County) <b>19</b>	(State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>6/4/60</b> , 19, to <b>3/26/66</b> , 19, that (I) (we) last saw the deceased alive on <b>3/26/66</b> , 19, and that death occurred at <b>GP</b> M, from causes and on the date stated above.						
22a. SIGNATURE <b>FB Thomas III M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/5/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Frank B Thomas III M.D.</b>		22d. ADDRESS <b>Hancock, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/6/66</b>	23c. NAME OF CEMETERY OR CEMETARY <b>ST. PETERS</b>	23d. LOCATION (City or Town) <b>HANCOCK, WASH. MARYLAND</b>		
24. FUNERAL DIRECTOR <b>Howard J. Stoen Hancock Md</b>		ADDRESS	25a. REC'D. BY REGISTRAR <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

06019

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06016

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>23 years</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>CHARLES</b>	Middle <b>WAYNE</b>	Last <b>EVERLY</b>	
4. DATE OF DEATH	Month <b>April</b>	Day <b>1</b>	Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1942</b>	
9. AGE (In years lost birthday) <b>23 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>servicing vending machine</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Md.</b>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles J. Everly</b>	14. MOTHER'S MAIDEN NAME <b>Mamie Boyce</b>	Address <b>Hagerstown, Md.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Charles J. Everly</b>	18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Multiple fractures of skull</b> DUE TO <b>auto accident.</b> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)	INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Collision with truck 3/30/66</b>		
20c. TIME OF INJURY Hour o.m. <b>2:00</b> Day, Year p.m. <b>3/30/66</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>W. Wash. Street</b>	20f. (City or town) <b>Hagerstown</b>	(County) <b>Wash.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>Howard N. Weeks, M.D.</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>580 Northern Ave., Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>4/4/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Lawn Mem. Gardens</b>	23d. LOCATION (City or Town) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>	ADDRESS <b>Hagerstown, Md.</b>	25a. REC'D BY REGISTRAR <b>APR 7 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

06020

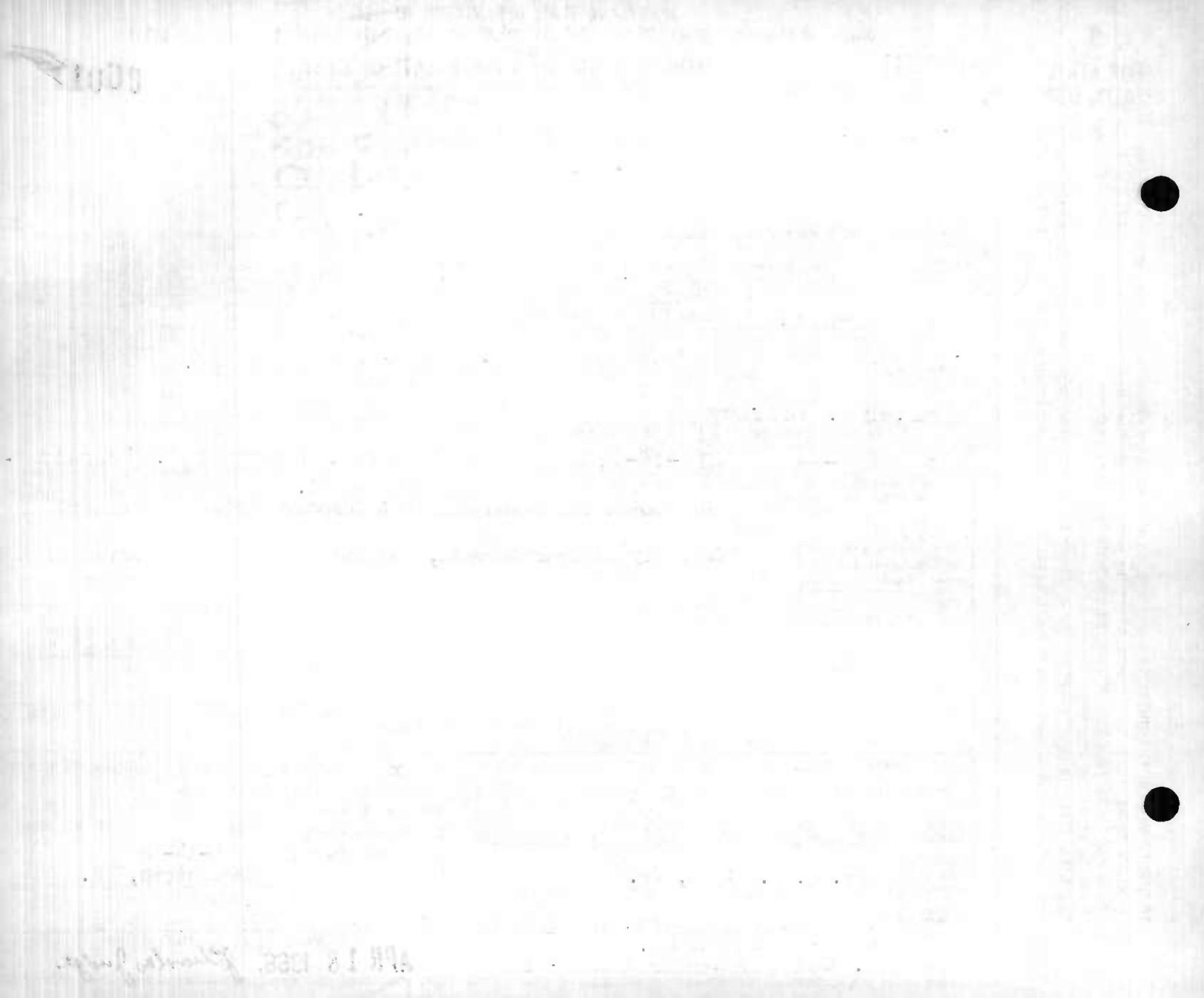
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06017

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Hrs</b>		b. COUNTY <b>Washington</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Air View Motel</b>		e. STREET ADDRESS <b>Emmert Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>FRANCIS COFFMAN</b>		First <b>FAHRNEY</b>	Middle <b>FAHRNEY</b>	Lost	4. DATE OF DEATH Month <b>April 13 1966</b>	
SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>August 27 1908</b>	9. AGE (In years last birthday) <b>57 yrs.</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surveyor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		
13. FATHER'S NAME <b>Walter S. Fahrney</b>		14. MOTHER'S MAIDEN NAME <b>Frances Coffman</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-16-1920</b>		17. INFORMANT Address <b>Miss Phyllis Fahrney 31 W. Franklin St</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hagerstown Md.				
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <b>Thrombotic Occlusion Of Right Coronary Artery</b>				
		DUE TO (c) <b>Coronary Atherosclerosis, Moderate</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
						Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.				
ACTUAL SIGNATURE <i>E. W. Ditto</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.				
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>		
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25a. ADDRESS <b>Hagerstown Md.</b>		25b. RECEIVED BY REGISTRAR DATE <b>APR 18 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1

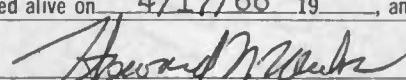
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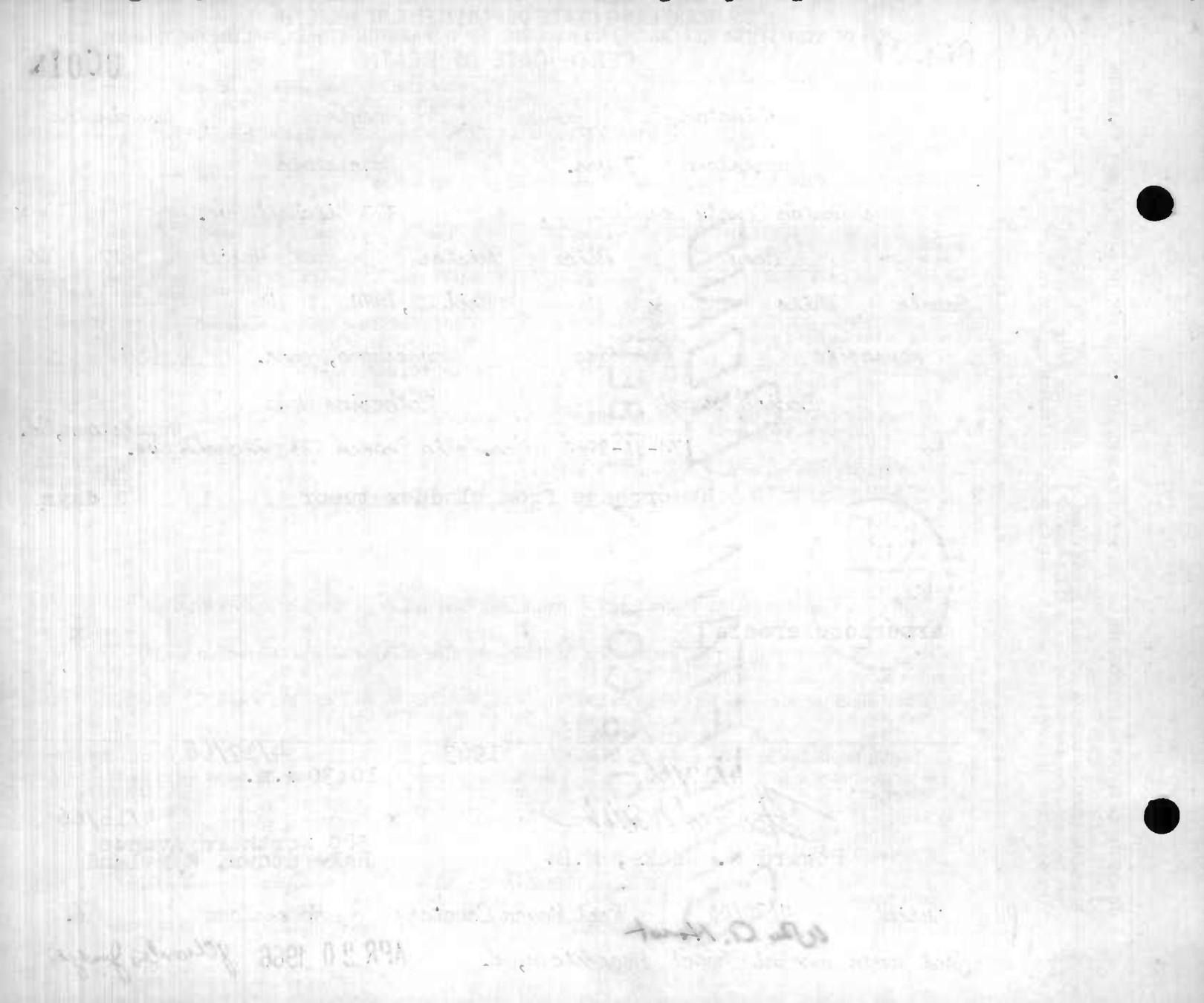
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M		06021										06018	
		1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
		a. COUNTY		Washington MARYLAND			a. STATE		Maryland Washington				
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
		Hagerstown		7 yrs.									
		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM?						
		Washington County Hospital					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
		3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
		Mary		Alice	Feister	April	17	19	66				
		5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS			
		Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 22, 1874	91	Months	Days	Hours			Min.
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
		Housewife			Own Home		Waynesboro, Penna.			USA			
		13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
		Daniel Runnel					Catherine Wade						
		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
		No		174-01-3580		Mrs. Lelia Crouse		323 Mitchell Ave.					Hagerstown, Md.
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH 2 days	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from bladder tumor  236X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arteriosclerosis										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.											
		p.m. 19											
		21. I certify that (I) (this hospital) attended the deceased from 1963, 19, to 4/17/66, 19, that (I) (we) last saw the deceased alive on 4/17/66 19, and that death occurred at 10:00 a.m. on the causes and on the date stated above.											
		22a. SIGNATURE 					22b. DATE SIGNED 4/18/66						
		Howard N. Weeks, M.D.											
		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		580 Northern Avenue							
		Howard N. Weeks, M.D.				Hagerstown, Maryland							
		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)			
		Burial		4/20/66		Rest Haven Cemetery		Hagerstown					
		24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		W.H. O. Horst				APR 20 1966		Charles Judge					
		B		DATE									
		Rest Haven Funeral Chapel Hagerstown, Md.											



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06022

06019

1. PLACE OF DEATH o. COUNTY <b>Washington</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>		c. LENGTH OF STAY IN 1b <b>1 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>212 W. Wilson Blvd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>G.</b>	Last <b>Fischer</b>	4. DATE OF DEATH Month <b>April</b>	Day <b>29</b>	Year <b>1966</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>October 20, 1888</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months <b>77</b>	IF UNDER 24 HRS. Hours <b>6 hrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>McLain Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Harris</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Madeline A. Sands, 212 W. Wilson Blvd. Hagerstown</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central asphyxia</b>							
DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial infarction</b>							
DUE TO (c) <b>atherosclerosis, generalized</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Diabetes mellitus</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>25 Apr 1966</b>	(County) <b>29 Apr 1966</b>	(State) <b>29 Apr 1966</b>
21. I certify that (I) (this hospital) attended the deceased from <b>25 Apr 1966</b> , to <b>29 Apr 1966</b> , that (I) (we) last saw the deceased alive on <b>29 Apr 1966</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. D. Wilson, M.D.</b>				M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/29/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>580 Northern Ave. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/4/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Greenlawn</b>	23d. LOCATION (City, town, or county) <b>Boro. Md</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Winfred F. N. 4101 Edmondson</b>		ADDRESS <b>an</b>		25a. REC'D BY REGISTRAR <b>Charles J. Hayes</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Hayes</b>		
VR A15 (4) 1SM 9/59		DATE <b>MAY 2 1966</b>					

CH-20-100

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

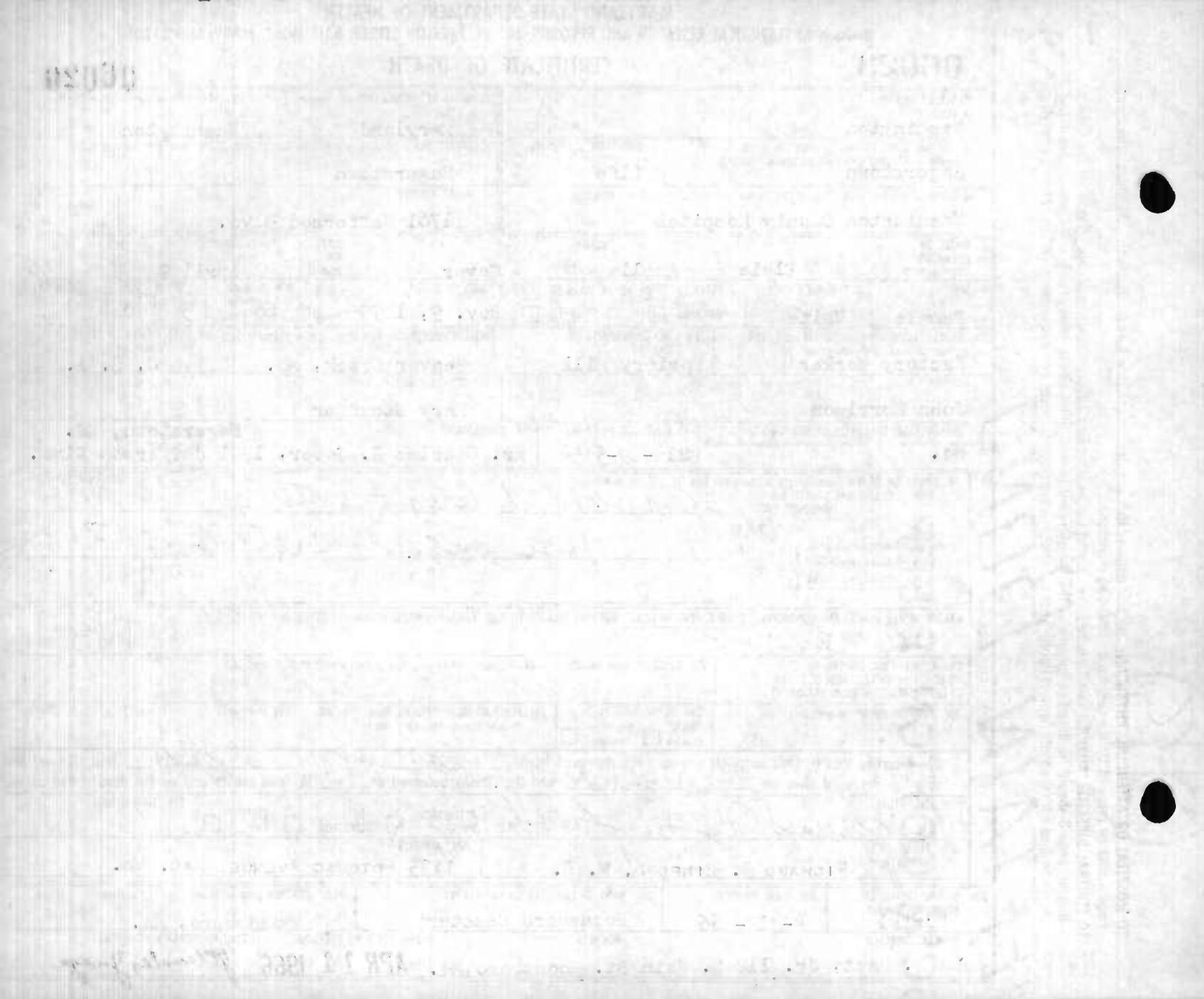
06023

## CERTIFICATE OF DEATH

06020

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>						d. STREET ADDRESS <b>1761 Jefferson Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Elsie</b>		First	Middle	Last	4. DATE OF DEATH <b>April 9</b>	Month	Day	Year		
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 9, 1899</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR <b>5</b> Months	IF UNDER 24 HRS. <b>0</b> Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hosiery Mill</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Beaver Creek, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>John Morrison</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stouffer</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-09-3354</b>		17. INFORMANT <b>Mr. Charles G. Gaver, 1761 Jefferson Blvd.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of breast with generalized metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>170x</b> (b) <b>Anemia</b> DUE TO (c) <b>31 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Anemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boonsboro Cemetery</b>	20f. (City or town) <b>Boonsboro</b>	(County) <b>Jefferson</b>	(State) <b>Md.</b>				
21. I certify that (I) (this hospital) attended the deceased from <b>16 Jan</b> , 19 <b>63</b> , to <b>Death</b> , 19 <b>63</b> ; that (I) (we) last saw the deceased alive on <b>8 April</b> , 19 <b>66</b> , and that death occurred at <b>2 pm</b> M, from causes and on the date stated above.						22b. DATE SIGNED <b>APR 14 1966</b>				
22c. SIGNATURE <b>Richard T. Binford</b>		22d. ADDRESS <b>1135 POTOMAC AVENUE HAG. MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-12-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) <b>Boonsboro</b>		(County) <b>Jefferson</b>		(State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr.</b>		ADDRESS <b>112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06024

## CERTIFICATE OF DEATH

06021

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>84 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WALTER SCOTT GIBNEY</b>		First <b>WALTER</b>	Middle <b>SCOTT</b>
Last <b>GIBNEY</b>	4. DATE OF DEATH Month <b>April</b>	Day <b>7</b>	Year <b>1966</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>May 8, 1881</b>	9. AGE (In years last birthday) <b>84 yrs.</b>	10. BUSINESS OR INDUSTRY <b>florist</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>Hagerstown, Md.</b>	13. FATHER'S NAME <b>George W. Gibney</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Hose</b>			Address <b>Mrs. Florence White, Hag., Md.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>217-32-5520</b>			
17. INFORMANT <b>Carcinoma of the prostate with metastasis to the liver</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X</b> DUE TO <b>Possibly 2 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Approximately</b>
21. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1966</b> , to <b>April 7, 1966</b> that (I) (we) last saw the deceased alive on <b>April 7, 1966</b> , and that death occurred at <b>8 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Walter Layman</b>		22b. DATE SIGNED <b>April 11, 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Walter Layman, M. D.,</b>		22d. ADDRESS <b>100 Professional Arts Bldg., Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/12/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		23d. LOCATION (City or Town) <b>Hagerstown Md.</b>	
		ADDRESS <b>Hagerstown, Md.</b>	25d. REGISTRAR'S SIGNATURE <b>APR 13 1966</b>
		DATE <b>APR 13 1966</b>	25e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

1800

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06025

## CERTIFICATE OF DEATH

06022

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		c. LENGTH OF STAY IN 1b <b>2 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reeder Nursing Home</b>			d. STREET ADDRESS <b>24 S. Hull St.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Elsie</b>	Last <b>Griffith</b>	4. DATE OF DEATH <b>April 3,</b>	Month Year <b>19 66</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 14, 1884</b>	9. AGE (In years lost birthday) <b>81 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Shepherdstown, W. Va.</b>	
13. FATHER'S NAME <b>James Coffenberger</b>			14. MOTHER'S MAIDEN NAME <b>Susan Flemming</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-54-0112</b>		17. INFORMANT <b>Mrs. Margaret Churchey, Sharpsburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency with congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>4201</b> DUE TO last. (c)					
INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Asthma and asthmatic bronchitis. cerebral AS.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>five years</b> or, to <b>more</b> , 19____, that (I) (we) last saw the deceased alive on <b>March 30 1966</b> and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <b>Walter H. Shealy</b>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>		22d. ADDRESS <b>Sharpsburg, Md. 21782</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-5-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Elmwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Shepherdstown, W. Va.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>			25a. RECD BY REGISTRAR <b>APR 11 1966</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1800

2500

## MARYLAND STATE DEPARTMENT OF HEALTH

06026

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06023

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>629 North Locust Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Gateway Convalescent Home, Inc.</b>								
3. NAME OF DECEASED (Type or print) <b>Robert Garland Haines</b>		First	Middle	Last	4. DATE OF DEATH <b>April 13 1966</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1900</b>	9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aircraft employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Romney, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Wesley Haines</b>		14. MOTHER'S MAIDEN NAME <b>Christina Cross</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>236-14-7917</b>		17. INFORMANT <b>Mrs. Mary Roach Haines -Hagerstown, Maryland</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>1621</b>		<b>METASTATIC CARCINOMA TO BRAIN &amp; LIVER</b>						
Conditions, if any, which give rise to immediate cause (e), stating the underlying cause first.		(b) <b>CARCINOMA, PULMONARY</b> (c)						
DUE TO								
DUE TO								
DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Pulmonary Embolism - Arteriosclerotic CVD disease - Coronary Artery Disease</b>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>17 February 1966</b> to <b>13 April 1966</b> , that (I) (we) last saw the deceased alive on <b>7 April 1966</b> , and that death occurred at <b>2 NOON</b> M., from the causes and on the date stated above.		22b. DATE SIGNED <b>15 April 1966</b>						
22a. SIGNATURE 		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) <b>W. N. Fender, M. D.</b>		22d. ADDRESS <b>218 N. Potomac St. Hagerstown, Md. 21740</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-16-1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Rosedale Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Martinsburg, Berkeley, W. Va.</b>		
24 FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS <b>Martinsburg, W. Va.</b>						
25e. REC'D BY REGISTRAR <b>APR 18 1966</b>		25f. REGISTRAR'S SIGNATURE 						

d.

2301 18 1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 M 06027		96024											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14 Roessner Ave.				d. STREET ADDRESS 14 Roessner Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First George Middle William Last Hammond		4. DATE OF DEATH April 29		Month Year									
5. SEX Male White		6. COLOR OR RACE WIDOWED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9 1878		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Kennedy Hammond				14. MOTHER'S MAIDEN NAME Wilhelmina Gower									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-20-8356		17. INFORMANT Mrs. Elsie P. Hammond		14 Roessner Ave. Hagerstown Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO (b) arterio sclerotic Heart D <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <span style="float: right;">deader</span>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arterio - sclerosis													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from April 18, 1966 to April 29, 1966 that (I) (we) last saw the deceased alive on April 29, 1966, and that death occurred at 1:30 PM, from the causes and on the date stated above.													
22a. SIGNATURE Sidney Movenstein		22b. DATE SIGNED 4-29-66											
22c. PHYSICIAN'S NAME (Type) SIDNEY MOVENSTEIN		22d. ADDRESS Funkstown MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 3 1966		23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		23d. LOCATION (City, town or county) Hagerstown Maryland		(State)					
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAY 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

3300

morning (around)

to well above water

water - water displaced

10 points of 20 points at 20%  
water

displaced

in surrounding vegetation

May 1 1928 100% water

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## **CERTIFICATE OF DEATH**

186025

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove ~~entire~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Western State Hospital MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western State Hospital 1509 S Avenue Hagerstown Md.		Rockville 15-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>MARTINA Olivia</i>	Middle	Last <i>HARRIS</i>	4. DATE OF DEATH	Month Day Year <i>April 20 1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 17, 1886</i>	9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Deys <i>0</i> Hours <i>0</i> Min. <i>0</i> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Charles County Md.</i>	
13. FATHER'S NAME <i>Alec Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Olivia Gross</i>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary Lassay</i> Address <i>926 1/2 Carolina Street</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i>	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>arteriosclerosis, general</i>		unknown	
DUE TO <i>331X</i>		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>(1) Pyelonephritis (2) Rheumatoid arthritis</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <u>(1) (his hospital)</u> attended the deceased from <i>Aug. 2, 1962</i> , to <i>April 20, 1966</i> , that <u>(2) (we)</u> last saw the deceased alive on <i>April 20, 1966</i> , and that death occurred at <i>8:45 AM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Sister L. Ramos</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>April 20, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>VICTOR L. RAMOS, M.D.</i>		22d. ADDRESS <i>western maryland state hospital Hagerstown, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF <i>4/23/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL Mt Olivert Cem.	
24. FUNERAL DIRECTOR Lowe's Funeral Home		23d. LOCATION (City, town or county) Wash. D. C.		(State)	
ADDRESS <i>1425 Mt. Ave., N. E.</i>		25a. REC'D BY REGISTRAR <i>APR 25 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

25/100

classical music

of anything

such as

not standard

atmosphere

with which

ments and

what you like

now

equilibrium between

energy, metabolism

which is called a

to which is a

which is called

a muscle is used

for

25/100

and I can do

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06029

## CERTIFICATE OF DEATH

06026

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>30 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 21-1							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>14 West Wilson Blvd.</b>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Grayson</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 6,</b>	Month	Day Year <b>19 66</b>				
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1910</b>	9. AGE (In years last birthday) <b>56 yrs.</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS. Days <b>6</b>	Hours <b>0</b>	Min. <b>0</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Auto.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Middletown, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Maurice Haupt</b>				14. MOTHER'S MAIDEN NAME <b>Anna Shank</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>214-10-4500</b>			17. INFORMANT <b>Mr. Gene A. Haupt</b>			Address <b>609 Summit Ave. Hagerstown</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Hepatic Coma				INTERVAL BETWEEN DEATH AND LAST MEAL <b>7 days</b>			
157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) Carcinoma of Pancreas				DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1012</b>		20f. (City or town) (County) (State) <b>Hagerstown</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>10/12</b> , 19 <b>65</b> to <b>April 6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>April 6</b> , 19 <b>66</b> , and that death occurred on <b>April 6</b> , 19 <b>66</b> , M, from causes and on the date stated above.											
22a. SIGNATURE <b>Donald E. Martin</b>				22b. DATE SIGNED <b>4/8/66</b>							
22c. PHYSICIAN'S NAME (Type) <b>Donald E. Martin M.D.</b>				22d. ADDRESS <b>418 N. Potomac St. Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-9-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Boonsboro Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>			
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
								APR 11 1966			

8800

✓ ~~new garage  
is wanted~~

✓ ~~dent 2nd visit~~  
2/12/44 x ~~dent 3rd visit~~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06030

CERTIFICATE OF DEATH

06027

1. PLACE OF DEATH  
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN 1b

40 YRS.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

931 OAK HILL AVENUE

3. NAME OF  
DECEASED  
(Type or print)

First  
CORA

Middle  
ELEANOR

Last  
HAUSRATH

4. DATE  
OF  
DEATH

APRIL

Month  
15  
Day  
19  
Year  
66

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

AUG. 15, 1880

9. AGE (In years  
last birthday)

85  
yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months  
Days  
Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (County & State, or foreign country)

BUFFALO MILLS PENNA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARMAN DeVORE

14. MOTHER'S MAIDEN NAME

ROSELLA MALSBERY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MRS. JOSEPHINE SEIBERT 22 BROADWAY

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

174X

DUE TO

Conditions, If any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

OUE TO

(c)

*metastatic carcinoma of  
uterus*

INTERVAL BETWEEN  
ONSET AND DEATH

1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

*parasitic and pernicious anemia*

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.

20d. INJURY OCCURRED  
While  Not While   
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)  
(County)  
(State)

21. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that death occurred at \_\_\_\_\_ M, from the causes and on the date stated above.

22a. SIGNATURE

*John C. Stauffer*

22b. DATE SIGNED

4/16/1966

22c. PHYSICIAN'S  
NAME (Type)

JOHN C. STAUFFER M.D.

22d. ADDRESS

145 S. PROSPECT ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

4/18/1966

23b. DATE THEREOF

REST HAVEN CEMETERY

ADDRESS

23d. LOCATION (City, town or county) (State)

HAGERSTOWN, MARYLAND

24. FUNERAL DIRECTOR

*Jackson L. Taylor*

ADDRESS

HAGERSTOWN, MARYLAND

25a. REC'D BY REGISTRAR

APR 20 1966

25b. REGISTRAR'S SIGNATURE

*Charles Judge*

330 01 938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06031

CERTIFICATE OF DEATH

06028

1. PLACE OF DEATH  
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN 1b

2 MOS.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

WASHINGTON COUNTY HOSPITAL

3. NAME OF  
DECEASED  
(Type or print)

First  
NELSON

Middle  
N.M.N.

Last  
HELLER

4. DATE  
OF  
DEATH  
APRIL

Day  
24  
Year  
1966

5. SEX

6. COLOR OR RACE  
MALE WHITE

7. MARRIED  
WIDOWED X

NEVER MARRIED  
DIVORCED

8. DATE OF BIRTH  
FEB. 5, 1887

9. AGE (in years  
last birthday)  
79 yrs.

10. IF UNDER 1 YEAR  
Months Days Hours Min.

11. IF UNDER 24 HRS.  
12. CITIZEN OF WHAT  
COUNTRY?  
U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED ENG. SUPERVISOR TELEPHONE CO.

11. BIRTHPLACE (County & State, or foreign country)  
BUCKS CO., PENNSYLVANIA

13. FATHER'S NAME

ALLEN B. HELLER

14. MOTHER'S MAIDEN NAME  
ALICE LANDIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO.

212-10-0611A

17. INFORMANT

NORMAN N. HELLER 115 JOHN STREET

HAGERSTOWN, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

2001 Hemorrhage from the upper intestinal tract  
DUE TO  
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.  
(b) Neoplasm, probably lymphosarcoma  
DUE TO  
(c) Ulceration of the tumor

INTERVAL BETWEEN  
ONSET AND DEATH  
UNKNOWN

approximate  
24 hours.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  
Chronic diverticulitis of the colon; arteriosclerotic heart disease.

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. ACCIDENT WAS UNDERLYING  
DR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. While at work   
p.m. Not While at work

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20e. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 26, 1965, to April 24, 1966, that (I) (we) last saw the deceased alive on 11 p.m. 4/23/66, and that death occurred at 2 a.m. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)

22b. DATE SIGNED  
4/25/1966

WALTER LAYMAN M.D.

22d. ADDRESS

PROFESSIONAL ARTS BG. HAGERSTOWN, MD.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

4/27/1966

23b. DATE THEREOF

ROSE HILL CEMETERY

ADDRESS

HAGERSTOWN, MARYLAND

DATE

23d. LOCATION (city, town or county) (State)

HAGERSTOWN, MARYLAND

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

CHARLES JUDGE

APR 29 1966



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06032

## CERTIFICATE OF DEATH

36029

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>2 Weeks</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Rfd. 1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
79									
3. NAME OF DECEASED (Type or print)		First <b>Lottie</b>	Middle <b>Ruth</b>	Last <b>Hennessey</b>	4. DATE OF DEATH <b>April 18,</b>	Month <b>1966</b>	Day <b>19</b>	Year <b>66</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 5, 1892</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR <b>8 Months</b>	IF UNDER 24 HRS. <b>13 Days</b>	Hours <b>2 Hours</b>	Min. <b>0 Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rural Downsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>George A. Daugherty</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Bloom</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. J. Omer Hennessey</b>		Address <b>Fairplay Rfd. 1, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>464 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Pneumonia embolus</b>		DUE TO (b) <b>habits?</b>		DUE TO (c) <b>24 hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia embolus</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Boonsboro</b>		(County) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2-28-1966</b> , to <b>4-18-1966</b> , that (I) (we) last saw the deceased alive on <b>4-18-1966</b> , and that death occurred at <b>Boonsboro</b> M, fram causes and on the date stated above.									
22a. SIGNATURE <b>Joseph Secondari</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>4-20-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>		22d. ADDRESS <b>Boonsboro Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-21-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Green Lawn Cemetery</b>		23d. LOCATION (City or Town) <b>Williamsport, Md.</b>		(County) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		(State)	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**06033**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)		a. STATE Maryland b. COUNTY Washington		b6039	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
Rural Wilson		5 weeks		Williamsport		107 S. Vermont St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Gateway Convalescent Home Inc.							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
William Norman Herbert				Herbert	APRIL	21	1966		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years less birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 24 1899	66 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Warper		Silk Mill		Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
George Herbert		Anna Bell Pitzer							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank date of service		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		216-10-9818		107 S Vermont St. Mrs. Ethel Herbert Williamsport, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		CEREBRO-VASCULAR THROMBOSIS							
4438 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		DUE TO (b) HYPERTENSIVE - ARTERIOSCLEROTIC C-V Disease						4 yrs.	
{		DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED						4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from 19 Feb. 1966 to 21 April 1966, that (I) (we) last saw the deceased alive on 21 April 1966, and that death occurred at 8:30 AM, from the causes and on the date stated above.									
22e. SIGNATURE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 21 April 66			
22c. PHYSICIAN'S NAME (Type)		W. N. FENDER		22d. ADDRESS 218 N. Potowmack St. Hagerstown, Md.					
23e. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Burial April 24-66		23c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		23d. LOCATION (City, town or county) Williamsport Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Albert L. Leaf Williamsport Maryland		25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE Charles J. Judge			
20M 5-63									

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G575 4/14/66 mh

06034

## CERTIFICATE OF DEATH

06031

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

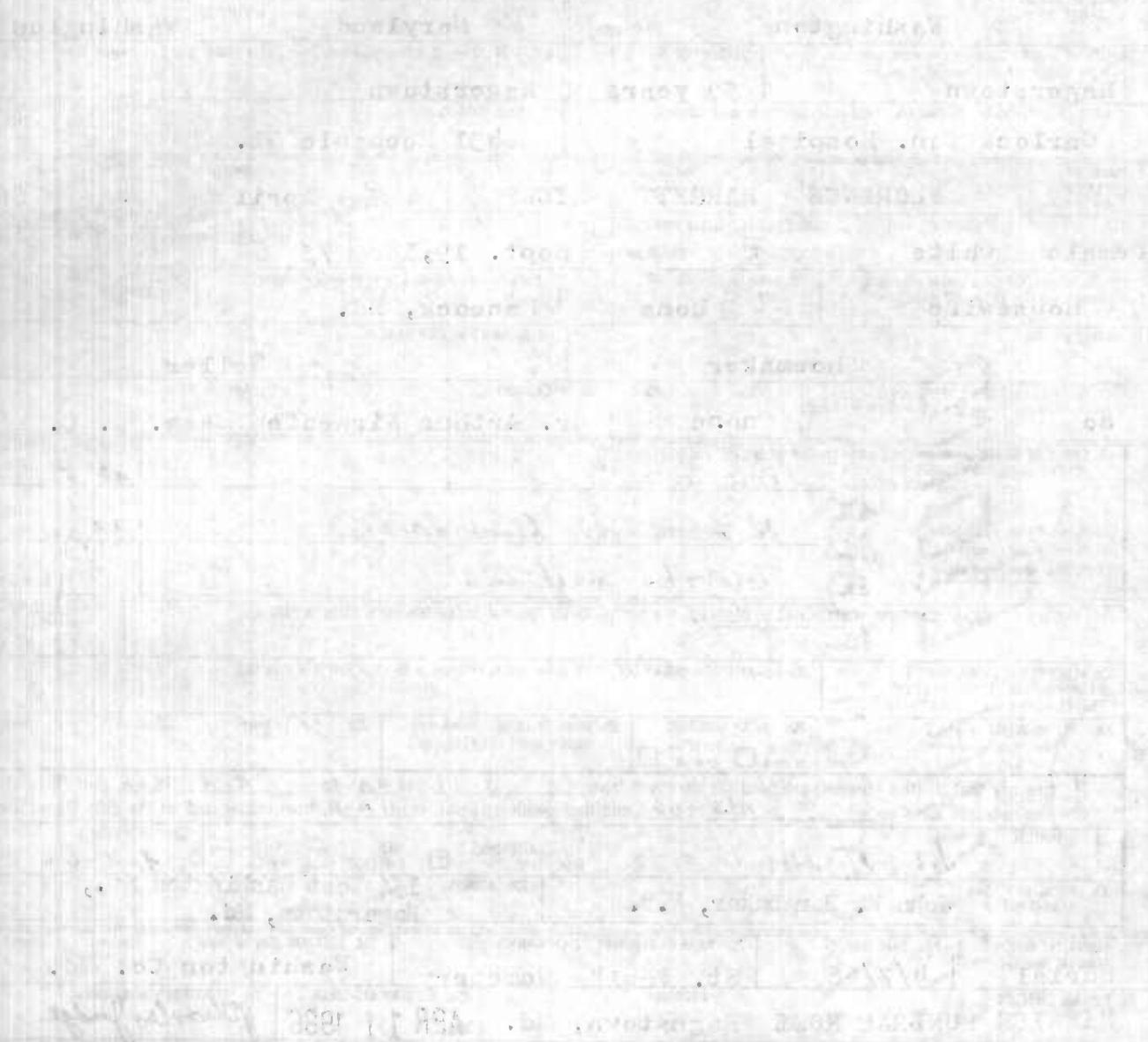
Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN lb <b>50 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	d. STREET ADDRESS <b>431 Mechanic St.</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Con. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FLORENCE HARRETT HICKS</b>		First <b>FLORENCE</b>	Middle <b>HARRETT</b>
4. DATE OF DEATH Month <b>April</b>	Month <b>4</b>	Doy <b>19</b>	Year <b>1966</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
B. DATE OF BIRTH <b>Sept. 19, 1889</b>	C. AGE (In years lost birthday) <b>75 76 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hancock, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Shoemaker</b>		14. MOTHER'S MAIDEN NAME <b>Weller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Dr. Arthur Kiracofe</b>		Address <b>Wash. D. C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Influenza</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>260X</b>			
(b) DUE TO <b>Hypertensive heart disease</b>		20 years?	
(c) DUE TO <b>Diabetes mellitus</b>		9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>154 West Washington St., Hagerstown, Md.</b>
20f. (City or town) <b>Washington Co. Md.</b>		(County) <b>Washington Co.</b>	(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>5-17, 1943</b> , to <b>4-4, 1966</b> , that (I) (we) last saw the deceased alive on <b>4/3/1966</b> , and that death occurred at <b>11A M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>4-5-66</b>	
22a. SIGNATURE <b>John H. Hombaker</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>John H. Hombaker, M.D.</b>		22d. ADDRESS <b>154 West Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/7/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Paul's Cemetery</b>
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06035

## CERTIFICATE OF DEATH

06032

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Then please file in carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please file in carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>			b. COUNTY <b>Washington</b>		
c. LENGTH OF STAY IN lb <b>3 Months</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Knoxville Rd. 1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reeder Nursing Home</b>			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>George William</b>	Middle <b>Holmes</b>	Lost	4. DATE OF DEATH	Month <b>April 22,</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1877</b>	Year IF UNDER 1 YEAR Months <b>89</b> yrs. 0 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Lumberman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>William S. Holmes</b>			14. MOTHER'S MAIDEN NAME <b>Mary E. Fauble</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No,</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT			Address <b>Mrs. Mabel Haller, Knoxville Rd. 1, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Severe Marasmus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
(b) DUE TO <b>General arterio-sclerosis</b>			<b>Year</b>		
(c) DUE TO <b>Congestive heart failure</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 11, 1960</b> , to <b>4-22-1966</b> , that (I) (we) last saw the deceased alive on <b>4-22-1966</b> , and that death occurred at <b>Boonsboro, Md.</b> from causes and on the date stated above.			22b. DATE SIGNED <b>4-23-66</b>		
22a. SIGNATURE <b>J. S. Gloude</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>			22d. ADDRESS <b>Boonsboro, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-25-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Burkittsville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Burkittsville, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>APR 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

06036

## CERTIFICATE OF DEATH

06033

**4**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Boonsboro</b>		c. LENGTH OF STAY IN lb <b>7 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahrney Keedy Home</b>			d. STREET ADDRESS <b>220 N. Locust St.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MIDDLE LAST		4. DATE OF DEATH Month Day Year			
<b>PAULINE HARSHMAN HOLINGER</b>		<b>April 6 1966</b>			
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1899	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>business offic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>	
13. FATHER'S NAME <b>Edward L. Smith</b>			14. MOTHER'S MAIDEN NAME <b>Cora Wolfe</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-18-9350</b>		17. INFORMANT Address <b>Myrtle L. Harmison Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Colon</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>					
1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Hagerstown</b>	(County) <b>Maryland</b> (State)
21. I certify that (I) <b>(initials)</b> attended the deceased from <b>1-24</b> , 19 <b>66</b> , to <b>4-10</b> , 19 <b>66</b> , that (I) <b>(initials)</b> last saw the deceased alive on <b>4-6</b> , 19 <b>66</b> , and that death occurred on <b>4-10</b> , 19 <b>66</b> , M, from causes and on the date stated above.					
22a. SIGNATURE <b>Dalton M. Welty</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/8/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dalton M. Welty, M.D.</b>		22d. ADDRESS <b>998 Potomac Avenue, Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/9/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) <b>Hagerstown</b> (County) <b>Maryland</b> (State)	
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		ADDRESS <b>Hagerstown Md.</b>	25d. REC'D BY REGISTRAR <b>APR 11 1966</b>	25e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

8600

Plan to implement

radio

protection

management

protection

efficiency

standards intact

industry's role

from local entities

REGULATION RATHER THAN STANDARDS

DO NOT USE VETO POWER TO DENY OTHERS' RIGHTS

PROTECTION OF PUBLIC RESOURCES IS A GOAL

PUBLIC USE OF PUBLIC LANDS

OFFICE OF THE

ON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06037

CERTIFICATE OF DEATH

06034

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.		b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Maugansville Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Maugansville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Maugansville, Md.		d. STREET ADDRESS		Maugansville, Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First MOSES	Middle K.	Last HORST	4. DATE OF DEATH	Month April	Day 3	Year 1966	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1882		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Minister church		11. BIRTHPLACE (County & State, or foreign country) Wash. Co., md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel E. Horst		14. MOTHER'S MAIDEN NAME Elizabeth Martin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Oliver Martin - Hagerstown, md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Indefinite							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral thrombosis due to cerebral arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease		Indefinite							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 1, 1966, to April 3, 1966, that (we) last saw the deceased alive on April 1, 1966, and that death occurred at 4:15 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 4/4/66							
22a. SIGNATURE B.B. Kneisley, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 W. Washington Street Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/66		23c. NAME OF CEMETERY OR CEMATORIUM Reaff Ch. Cemetery		23d. LOCATION (City, town or county) Wash. Co., Md.		(State)	
24. FUNERAL DIRECTOR A.E. Munich-Green castle, Pa.		ADDRESS		25a. REC'D BY REGISTRAR APR 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		(State)	
DATE				DATE					

1. *Urgent*  
2. *Important*  
3. *Informational*

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06038

CERTIFICATE OF DEATH

06035

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>12 Hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		d. STREET ADDRESS <b>Rfd. 1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Wanda</b>	Middle <b>Lee</b>	Last <b>Huffer</b>	4. DATE OF DEATH <b>April 14, 1966</b>	Month <b>April</b>	Day <b>14</b>	Year <b>1966</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1935</b>	9. AGE (In years last birthday) <b>30 yrs.</b>	IF UNDER 1 YEAR <b>10 Months</b>	IF UNDER 24 HRS. <b>9 Days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Gapland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward L. Oakes</b>				14. MOTHER'S MAIDEN NAME <b>Grace V. Crowl</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>214-34-9412</b>		17. INFORMANT <b>Mr. Delbert M. Huffer Boonsboro, Rfd. 1 Md.</b>			
Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A few consecutive of Right ovary</i> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause lost. DUE TO (c) _____								
INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Boonsboro</b>	(County) <b>Md.</b>	(State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4-1</b> , 19 <b>66</b> , to <b>4-15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-14</b> , 19 <b>66</b> , and that death occurred at <b>10 AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <i>Joseph Secondari</i>				M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4-15-66</b>	
22c. PHYSICIAN'S NAME (Type)		<b>JOSEPH SECONDARI</b>		22d. ADDRESS <b>Boonsboro Rd</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-17-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Boonsboro Cemetery</b>		23d. LOCATION (City or Town) <b>Boonsboro, Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				ADDRESS		25a. RECD BY REGISTRAR <b>APR 21 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		M 06039										06036	
1. PLACE OF DEATH a. COUNTY		Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					a. STATE		Md.						
Rural - Hagerstown					b. COUNTY		Wash.						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					Rural - Hagerstown		21-1						
H Washington County Hospital					d. STREET ADDRESS		Hagerstown RD2						
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
GEORGE		MARTIN	KEENER		April	30	19	66					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS						
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/22/1911	54 yrs.	Months	Days	Hours					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Dairy Owner and Operator					Cearfoss, Md.			USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Aaron D. Keener		Anna H. Martin											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	Keener			Address					
No		215-36-7094		Mrs. Esther Keener				Hagerstown RD2, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute myocardial infarction						Short					
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	Atherosclerotic Heart Disease						8 yrs.				
		DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)					
19													
21. I certify that (I) (this hospital) attended the deceased from April 30, 1966, to April 30, 1966, that (I) (we) last saw the deceased alive on April 30, 1966, and that death occurred at 5:45 P.M. from the causes and on the date stated above.								22b. DATE SIGNED					
22a. SIGNATURE		Edson B. Moody			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				4/30/66				
22c. PHYSICIAN'S NAME (Type)		Edson B. Moody			22d. ADDRESS	Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)					
B.		5/3/66		Reiff Church Cem.		Cearfoss, Md.							
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
A.C. Minich - Greencastle, Pa.					MAY 2 1966		Charles Judge						

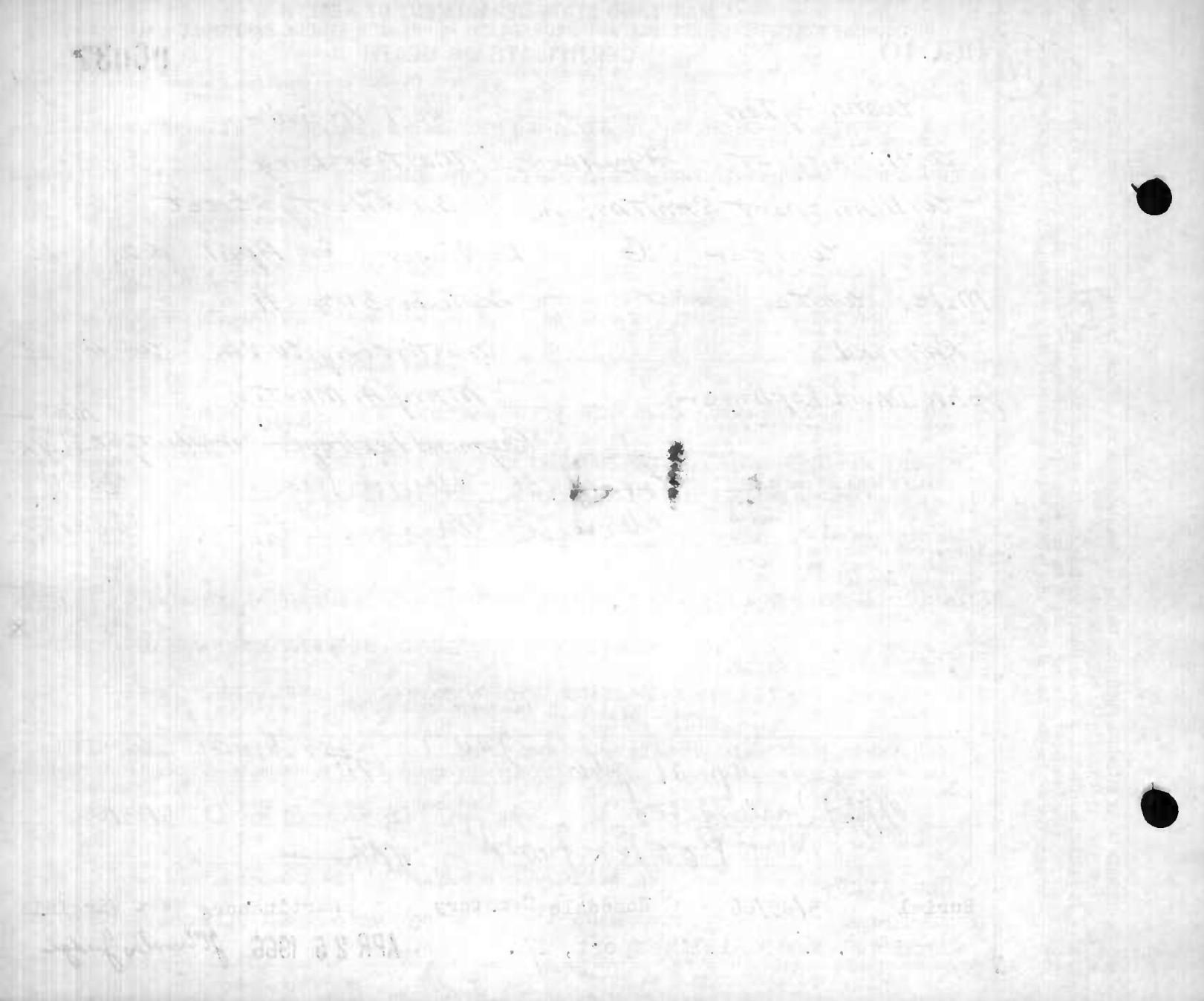


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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			186037		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)													
a. COUNTY <i>Washington</i> MARYLAND				b. STATE <i>West Virginia</i> b. COUNTY													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i> <i>Pennsylvania</i>				c. LENGTH OF STAY IN 1b													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Williamsport Sanitarium</i>				d. STREET ADDRESS <i>311 Liberty Street</i>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First <i>Walter</i> Middle <i>G.</i> Last <i>Keplinger</i>				4. DATE OF DEATH <i>April 22, 1966</i>													
Type or print) <i>Male</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>September 3 1874</i> 9. AGE (in years last birthday) <i>91 yrs.</i> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>								10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad</i> 10b. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME <i>John David Keplinger</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Martinsburg, W. Va.</i>								12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>17. INFORMANT</i> <i>Mary A. Martin</i> (son) Address				14. MOTHER'S MAIDEN NAME <i>Mary A. Martin</i>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>4222</i> DUE TO <i>chronic Myocarditis</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>20 years</i> (c)				INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> While at work <input type="checkbox"/> Not White <input type="checkbox"/> p.m. <i>19</i> at work <input type="checkbox"/>				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1966</i> to <i>Apr 21, 1966</i> , that (I) (we) last saw the deceased alive on <i>Apr 21, 1966</i> , and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above.												22b. DATE SIGNED <i>4/23/66</i>					
22a. SIGNATURE <i>M.H. Porterfield</i>				22b. DATE SIGNED <i>4/23/66</i>													
22c. PHYSICIAN'S NAME (Type) <i>M.H. Porterfield</i>				22d. ADDRESS <i>M.D.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>4/25/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rosedale Cemetery</i>		23d. LOCATION (City, town or county) <i>Martinsburg</i>		(State) <i>West Virginia</i>							
24. FUNERAL DIRECTOR <i>Jennie E. Leaf Williamsport, Md.</i>				ADDRESS								25a. REC'D BY REGISTRAR <i>APR 25 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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06041

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06038

## 1. PLACE OF DEATH

a. COUNTY  
Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

1 Year

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Martin Manor Rest Home Va. Ave.

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Annie Alice May

4. DATE  
OF  
DEATH

Last Kinna

Month April

Day 19

Year 66

## 5. SEX

Female

## 6. COLOR OR RACE

White

## 7. MARRIED

 NEVER MARRIED 

## 8. DATE OF BIRTH

Feb. 2, 1871

9. AGE (In years  
last birthday)

95 yrs.

## 10. IF UNDER 1 YEAR

Months

## 11. IF UNDER 24 HRS.

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House wife

## 11b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Chewsville Md.

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

Daniel Bachtell

## 14. MOTHER'S MAIDEN NAME

Barbra Coss

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or date of service)

no

## 16. SOCIAL SECURITY NO.

no

## 17. INFORMANT

Mrs. Charlotte P Kinna

Box #18 Chewsville Md.

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Congestive heart failure

INTERVAL BETWEEN  
ONSET AND DEATH

24 hours

4500

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

Pneumonia

24 hours

DUE TO

(c)

Arteriosclerosis

10 years

## 19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m.  
p.m.20d. INJURY OCCURRED  
While at work  Not While at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from..... 11-9, 1954, to..... 4-6, 1966, that (I) (we) last  
saw the deceased alive on..... 4-6, 1966, and that death occurred at 545 PM, from the causes and on the date stated above.

## 22e. SIGNATURE

Charles F. Hess

M.D.

ATTENDING  
PHYS. MED.  
DIRECTOR STAFF  
PHYS.

4-7-66

22b. DATE  
SIGNED22c. PHYSICIAN'S  
NAME (Type)

Charles F. Hess, M.D.

## 22d. ADDRESS

Smithsburg, Maryland 21783

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 23b. DATE THEREOF

April 8, 66

## 23c. NAME OF CEMETERY OR CREMATORIUM

Smithsburg Lutheran

## 23d. LOCATION (City, town or county) (State)

Smithsburg

## 24 FUNERAL DIRECTOR'S SIGNATURE

Minnich Funeral Home

## ADDRESS

Smithsburg Md.

## 25a. REC'D BY REGISTRAR

## 25b. REGISTRAR'S SIGNATURE

APR 11 1966

Charles Judge

1600

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06042

## CERTIFICATE OF DEATH

06039

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND							
M		CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>15 min</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>									
3. NAME OF DECEASED (Type or print)		First <b>Engler</b>	Middle <b>S.</b>	Last <b>Kipe</b>	4. DATE OF DEATH <b>April 4 1966</b>	Month <b>April</b>	Day <b>4</b>	Year <b>1966</b>	
5. SEX		6. COLOR OR RACE <b>Male</b> White	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1900</b>	9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cavetown Planing Mill</b> Carroll Co., Md.					
13. FATHER'S NAME <b>Samuel A. Kipe</b>				14. MOTHER'S MAIDEN NAME <b>Martha Gallion</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>n• 215-05-7299</b>		17. INFORMANT <b>Mrs. Harry Lewis</b>		Address <b>Cavetown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 443X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> (c) DUE TO DUE TO DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-7, 1955</b> , to <b>4-4, 1966</b> , that (I) (we) last saw the deceased alive on <b>4-4 1966</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Charles F. Hess</i>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4-6-66							
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M.D.</b>		22d. ADDRESS <b>Smithsburg, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/7/1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Bethel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick Co., Md.</b>			
24. FUNERAL DIRECTOR <i>Walter J. Hess</i>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 M 06043		2 06043	
1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		b. COUNTY <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>16 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>Mill St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u>		First	Middle
4. DATE OF DEATH <u>April 14, 1966</u>		Last	Month Day Year
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>April 18, 1886</u>		9. AGE (in years last birthday) <u>79 yrs.</u>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Duties</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Clear Spring, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Miller</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Miller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> None	
16. SOCIAL SECURITY NO. <u>215-14-1295</u>		17. INFORMANT Address <u>W. Harold Lesher. Clear Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion with myocardial infarction</u> DUE TO <u>4201</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO <u>6 years</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 17, 1966</u> to <u>April 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 14, 1966</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.		22b. DATE SIGNED <u>April 16, 1966</u>	
22a. SIGNATURE <u>Archie Robert Cohen</u>		22b. DATE SIGNED <u>April 16, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>		22d. ADDRESS <u>Clear Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/17/66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Rose Hill Cemetery</u>
24. FUNERAL DIRECTOR <u>Margaret Rawland</u>		ADDRESS <u>Clear Spring, Md.</u>	25a. REC'D BY REGISTRAR <u>APR 19 1966</u>
			25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>

300

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

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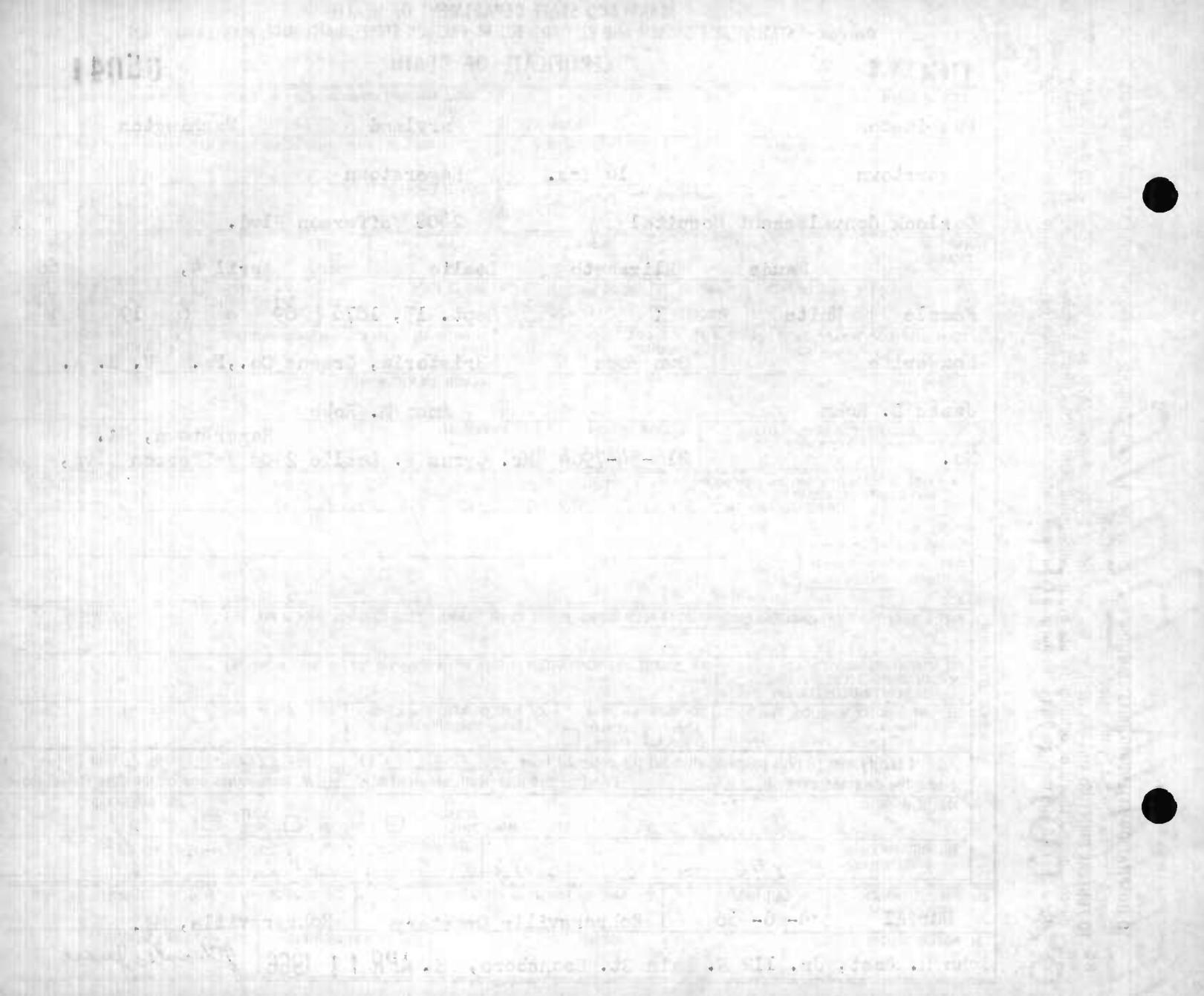
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06044

## CERTIFICATE OF DEATH

06041

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>16 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>2408 Jefferson Blvd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Convalescent Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Maude Elizabeth Leslie</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 4,</b>	Month	Doy Year <b>1966</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1876</b>	9. AGE (In years last birthday) <b>89 yrs.</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Dys <b>19</b> Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Bristoria, Greene Co., Pa.</b>	
13. FATHER'S NAME <b>James D. Rohm</b>				14. MOTHER'S MAIDEN NAME <b>Anna M. Robb</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>216-54-7964</b>		17. INFORMANT <b>Mr. Cyrus E. Leslie</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Arteriosclerosis, generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b> DUE TO <b>4500</b> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Fracture left hip.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>2408 Jefferson Blvd.</b>	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>1952</b> , to <b>4/4</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>17</b> 19 <b>66</b> , and that death occurred at <b>830A</b> M, from causes and on the date stated above.							
22o. SIGNATURE <b>George Jennings</b>							
22c. PHYSICIAN'S NAME (Type) <b>George Jennings, M.D.</b>		22d. ADDRESS <b>318 N. Potomac St. Hagerstown, Md.</b>					
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4- 6- 66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rohrersville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rohrersville, Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				ADDRESS	25o. REC'D BY REGISTRAR <b>APR 11 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1  
06042

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		b. COUNTY <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>7 Weeks</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Roger</b>		First <b>Samuel</b>	Middle <b>Lidie</b>		
4. DATE OF DEATH <b>April 11</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1879</b>		
9. AGE (In years last birthday) <b>86 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Co.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13. FATHER'S NAME <b>Samuel Lidie</b>	14. MOTHER'S MAIDEN NAME <b>Carlean M. Biggs</b>	Address <b>316 Avon Rd. Hagerstown, Md.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Carlean A. Stoner</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Myocarditis acute</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic heart disease</b> (b) DUE TO Cerebral arteriosclerosis (c)	INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture left femur; Prostatic hypertrophy</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>1-26-79</b>	20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>death</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 1966 to....., 19....., that (I) (we) last saw the deceased alive on....., 1966, and that death occurred <b>2:35 PM</b> , from the causes and on the date stated above.	22a. SIGNATURE <b>Robert F. Keader M.D.</b>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4-12-66</b>
22c. PHYSICIAN'S NAME (Type) <b>ROBERT F KEADER</b>	22d. ADDRESS <b>Hagerstown Md</b>	23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/13/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>U.B. Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Thurmont Fredk. Co. MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E Creager</b>	25a. REC'D BY REGISTRAR <b>APR 14 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FEDERAL BUREAU OF INVESTIGATION

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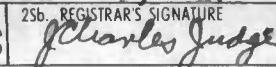
## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06046

## CERTIFICATE OF DEATH

06043

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 137 East Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First LOUELLA Middle PAULINE Last LLOYD		4. DATE OF DEATH April 1, 1966		Month		Doy Year	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1905	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Hag. Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Myers				14. MOTHER'S MAIDEN NAME Mary Alice Mummert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-0772		17. INFORMANT Carroll W. Lloyd 137 East Avenue, hagerstown, maryland Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis, plural- $5\frac{1}{2}$ yrs, cerebral-3months, DUE TO and to 10th dorsal vertebra- $5\frac{1}{2}$ yrs. 1989 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intraductal carcinoma DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 13 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Terminal pneumonia							
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 30, 1966 to April 1, 1966, that (I) (we) last saw the deceased alive on April 1, 1966, and that death occurred at 8:25 AM, from causes and on the date stated above.							
22o. SIGNATURE 				22b. DATE SIGNED April 2, 1966			
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.				22d. ADDRESS 5 Public Square Hagerstown, Maryland			
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/66		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hag. Wash. Co., Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Hagerstown, Md.				25a. REC'D BY REGISTRAR APR 11 1966 25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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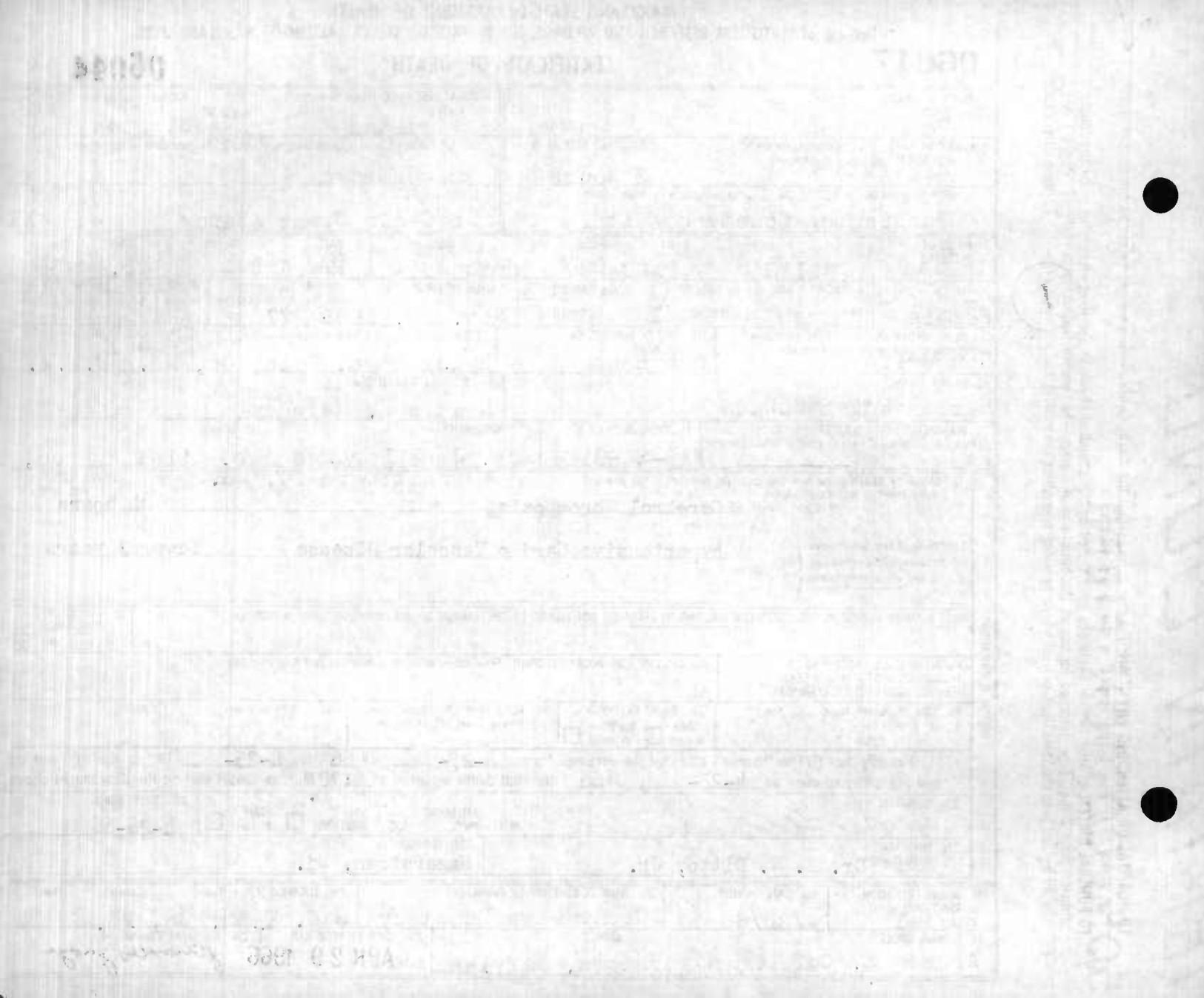
## CERTIFICATE OF DEATH

06044

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

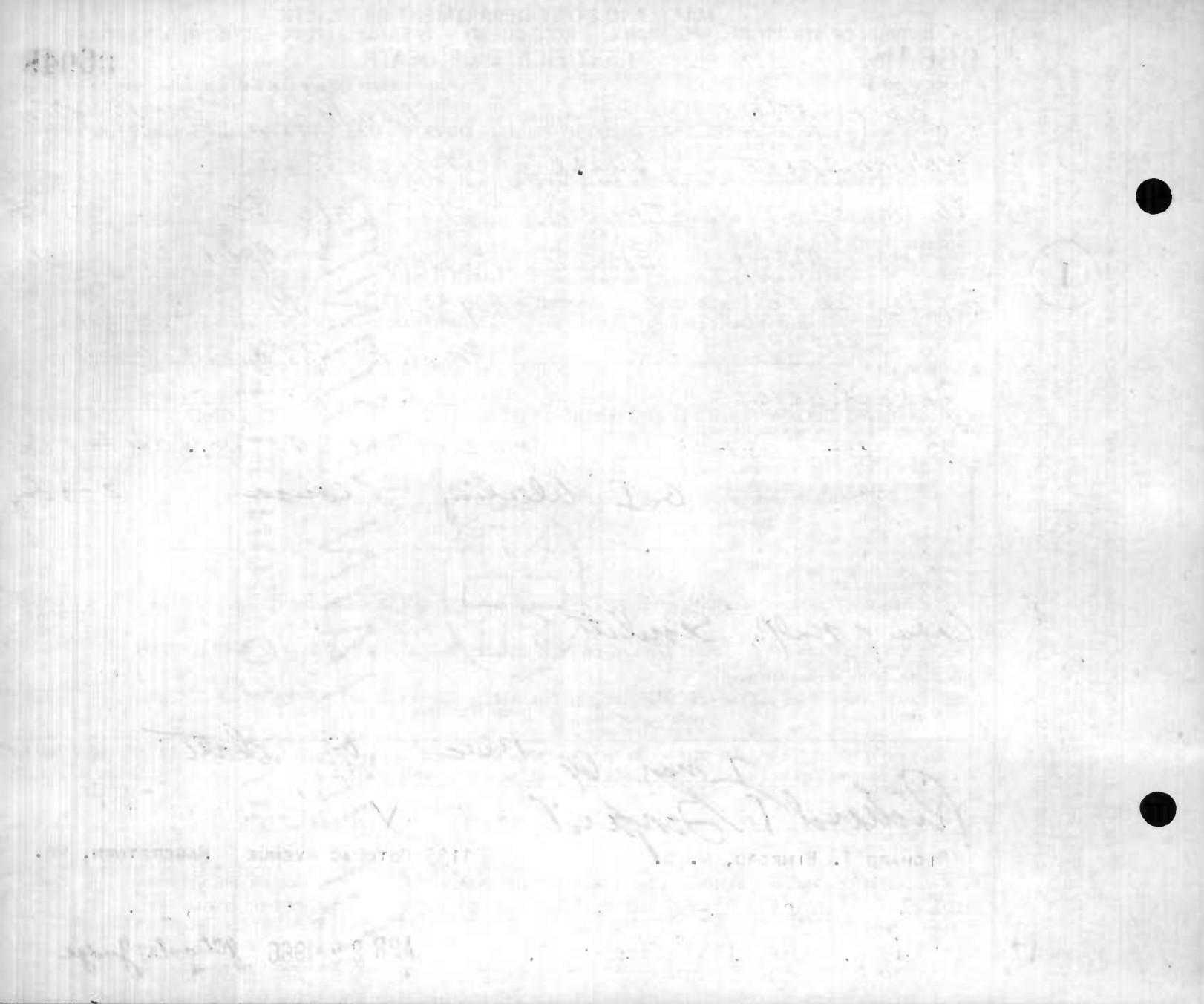
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>5 Cedar Crest Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDITH MARGARET LONG</b>		First	Middle
4. DATE OF DEATH <b>April 35, 1966</b>	Month	Day	Year
S. SEX <b>Female</b>	5. COLOR OR RACE <b>White</b>	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
B. DATE OF BIRTH <b>Nov. 16, 1888</b>	C. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Wash. Co., Md. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harlan Edgar McDade</b>		14. MOTHER'S MAIDEN NAME <b>Loutie F. Hershey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>318-30-9164</b> 17. INFORMANT <b>Mrs. Jane Sprague 3310 Ailsa Avenue, Baltimore 14, Md.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 14 hours	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> Several years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-25-1966</b> , to <b>4-25-1966</b> , that (I) (we) last saw the deceased alive on <b>4-25-1966</b> , and that death occurred at <b>6:30 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. E. W. Ditto</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4-26-66</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/28/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Lawn Cemetery</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Hagerstown, Maryland</b>		25a. RECEIVED BY REGISTRAR <b>APR 29 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										06048		06045	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)								
a. COUNTY Washington MARYLAND					a. STATE Maryland					b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSPORT					c. LENGTH OF STAY IN 1b 6 week					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WILLIAMSPORT SANITARIUM					d. STREET ADDRESS 735 DALE ST.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First MARY Elmer Loveless		Last		4. DATE OF DEATH April 18, 1966		Month		Day		Year			
Type or print) Female White		5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug 31, 1878		9. AGE (In years last birthday) 87 yrs.			
Housewife		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>				10. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Front Royal, Virginia U.S.A.			
13. FATHER'S NAME JAKE Loveless		14. MOTHER'S MAIDEN NAME Barbara Loveless		15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. DELLA Bond		Address 735 Dale St. Hagerst. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)													
C & I bleeding ? cause INTERVAL BETWEEN ONSET AND DEATH 2-3 days													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cancer of rect. Senility													
20a. MEDICAL CERTIFICATION		ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 Dec 1965 to 10 Apr 1966, that (I) (we) last saw the deceased alive on 21 Mar 1966, and that death occurred at 10 AM, from the causes and on the date stated above.		22b. DATE SIGNED		22c. SIGNATURE Richard T. Binford, M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 1135 POTOMAC AVENUE HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 21-66		23c. NAME OF CEMETERY OR CREMATORI Rosehill Cemetery		23d. LOCATION (City, town or county) Hagerstown, Md. (State)							
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.		ADDRESS		25a. REC'D BY REGISTRAR APR 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							



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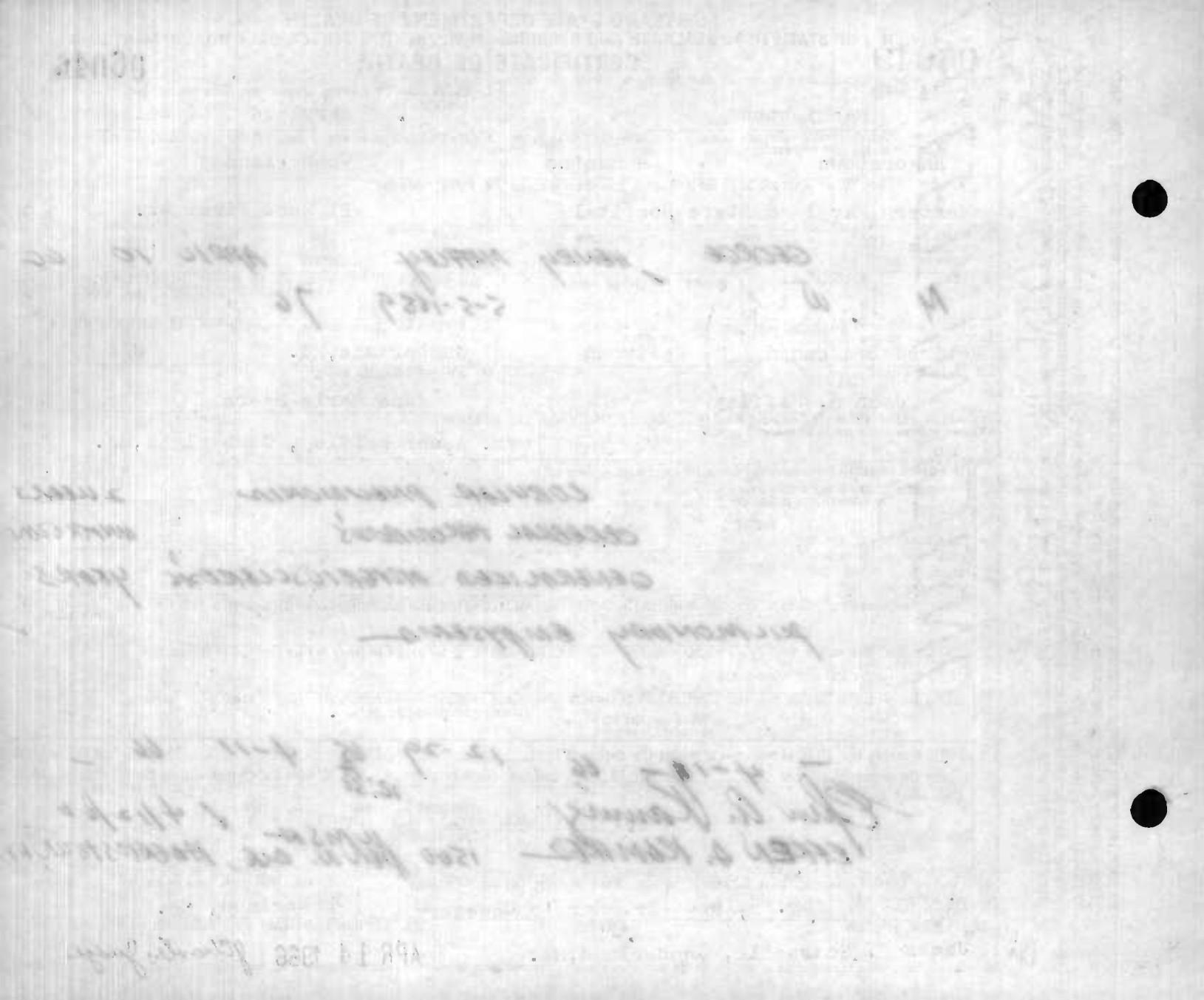
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06049

06046

1. PLACE OF DEATH a. COUNTY	Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	Maryland b. COUNTY Allegany ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Hagerstown			c. LENGTH OF STAY IN 1b	4 months							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Western Maryland State Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21 West First St.							
3. NAME OF DECEASED (Type or print)	First <i>GEORGE</i>	Middle <i>HENRY</i>	Last <i>MAFFLEY</i>	4. DATE OF DEATH	Month <i>APRIL</i>	Day <i>10</i>	Year <i>1966</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-5-1889</i>	9. AGE (In years (last birthday) <i>76</i> yrs.)	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Brakeman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Cumberland, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
13. FATHER'S NAME <i>John H. Maffley</i>	14. MOTHER'S MAIDEN NAME <i>Anna Marie Myers</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>Mrs. Agnes Maffley, Cumberland, Md.</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CEREBRAL INFARCTION</i>												
DUE TO (c) <i>CEREBRAL THROMBOSIS</i>												
DUE TO <i>GENERALIZED ARTERIOSCLEROSIS</i>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>PULMONARY EMPYSEMA</i>												
INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>												
UNKNOWNS												
YEARS												
MEDICAL CERTIFICATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>White at work</i>						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>HAGERSTOWN</i>	(County) <i>W.M.D.</i>	(State) <i>MARYLAND</i>
21. I certify that (I) (this hospital) attended the deceased from <i>12-29, 1966</i> , to <i>4-11, 1966</i> , that (I) (we) last saw the deceased alive on <i>4-11, 1966</i> , and that death occurred at <i>12:30</i> M, from the causes and on the date stated above.	22a. SIGNATURE <i>Eugen A. Ramirez</i>	22b. DATE SIGNED <i>4/12/66</i>										
22c. PHYSICIAN'S NAME (Type) <i>Eugen A. Ramirez</i>	22d. ADDRESS <i>1500 Penn Ave., HAGERSTOWN, MD</i>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Apr. 13, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Cemetery</i>	23d. LOCATION (City, town or county) <i>Cumberland, Md.</i>	(State) <i>MARYLAND</i>								
24. FUNERAL DIRECTOR <i>James F. Scarpelli, Cumberland, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>APR 14 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									
VR A15 (4) 20M 1/65												



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06050

## CERTIFICATE OF DEATH

06047

## 1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

3 Weeks

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

79  
Washington County Hospital3. NAME OF  
DECEASED  
(Type or print)First MIDDLE  
MOLIE SOPHIE

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

e. STATE

Maryland

b. COUNTY

Washington

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED 

8. DATE OF BIRTH

Feb. 31, 1888

9. AGE (In years  
last birthday)

78 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

12. Day

Year

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County &amp; State, or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Borah Kristal

14. MOTHER'S MAIDEN NAME

Etta Kaplan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

318-30-9467 Samuel S. Mansh 1133 Hamilton Blvd.,  
Hagerstown, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral embolism

INTERVAL BETWEEN  
ONSET AND DEATH

Sudden

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.(b) arteriosclerotic cardiovascular disease  
with auricular fibrillation

Years

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. While Not While  
p.m. at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 1966, to April 1966, that (I) (we) last  
saw the deceased alive on 4/29/66, and that death occurred at 11 P.M. from the causes and on the date stated above.

22e. SIGNATURE

M.D.

22b. DATE  
SIGNED  
4/30/6622c. PHYSICIAN'S  
NAME (Type)

Howard N. Weeks, M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS. 

22d. ADDRESS

580 Northern Avenue  
Hagerstown, Maryland23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial May 1, 1966 B'Nai Abraham Cen.

23d. LOCATION (City, town or county)

(State)

Hag. Wash. Co., Md.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Andrew K. Coffman Hagerstown, Maryland

MAY 6 1966

Charles Judge

800 3

800 3

800 3

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE			b. COUNTY			b. ADDRESS				
WASHINGTON MARYLAND			MARYLAND			WASHINGTON			HAGERSTOWN				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 2 HRS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			d. STREET ADDRESS 407 GUILFORD AVE.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 S. POTOMAC STREET									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First LIVIS	Middle VALENTINE	Last MARTIN	4. DATE OF DEATH APRIL 5	Month 1966	Day Year 5 19 66						
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 14, 1900	9. AGE (In years last birthday 66 yrs.	10. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME WILLIAM MARTIN	14. MOTHER'S MAIDEN NAME ELIZABETH GEARHART	HAGERSTOWN, MD.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NO		17. INFORMANT 705-10-7521A		MRS. RUTH MARTIN 407 GUILFORD AVE.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease = Coronary occlusion</i>   INTERVAL BETWEEN ONSET AND DEATH immed 4201 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.   (b) <i>Hypertension</i>   years - DUE TO (c) <i>Cerebral arteriosclerosis</i>   years .													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) HAGERSTOWN		(County) MARYLAND		(State)			
19													
21. I certify that (1) this hospital attended the deceased from <i>March 1966</i> , to <i>April 5, 1966</i> , that (2) we last saw the deceased alive on <i>3/22 1966</i> , and that death occurred at <i>83rd St. M.</i> from the causes and on the date stated above.													
22a. SIGNATURE <i>Philip J. Hirshman</i>		22b. DATE SIGNED <i>4/6/1966</i>											
22c. PHYSICIAN'S NAME (Type) PHILIP J. HIRSHMAN M.D.		22d. ADDRESS 159 W. WASHINGTON ST. HAGERSTOWN, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 8, 1966		23c. NAME OF CEMETERY OR CREMATORIUM REST HAVEN CEMETERY		23d. LOCATION (City, town or county) HAGERSTOWN		(State) MARYLAND					
24. FUNERAL DIRECTOR <i>Charles L. Lasson</i>		ADDRESS HAGERSTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE APR 11 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

06052

## CERTIFICATE OF DEATH

116049

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>46 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>331 S. Potomac St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jackson Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MAUDE LORENA MARTIN</b>		First	Middle
4. DATE OF DEATH <b>April 26 1966</b>		Last	Month Doy Year
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>Mar. 9, 1889</b>		9. AGE (In years last birthday) yrs. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe mfg.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Harpers Ferry, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William H Nichols</b>		14. MOTHER'S MAIDEN NAME <b>Amanda C. Flook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-0699</b>	
17. INFORMANT <b>Mrs. Ruth Winks</b>		Address <b>Martinsburg, W. Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastasis, intra-abdominal and hepatic</b> DUE TO 1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma of sigmoid</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>			
indeterminate. (15 months certain)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive cardiovascular disease; arthritis dorsal and lumbar spine.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 1965</b> , to <b>April 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 25 1966</b> , and that death occurred at <b>2:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/26/66</b>
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		22d. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/28/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME Hagerstown, Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>APR 29 1966</b>
			25b. REGISTRAR'S SIGNATURE 



1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06053

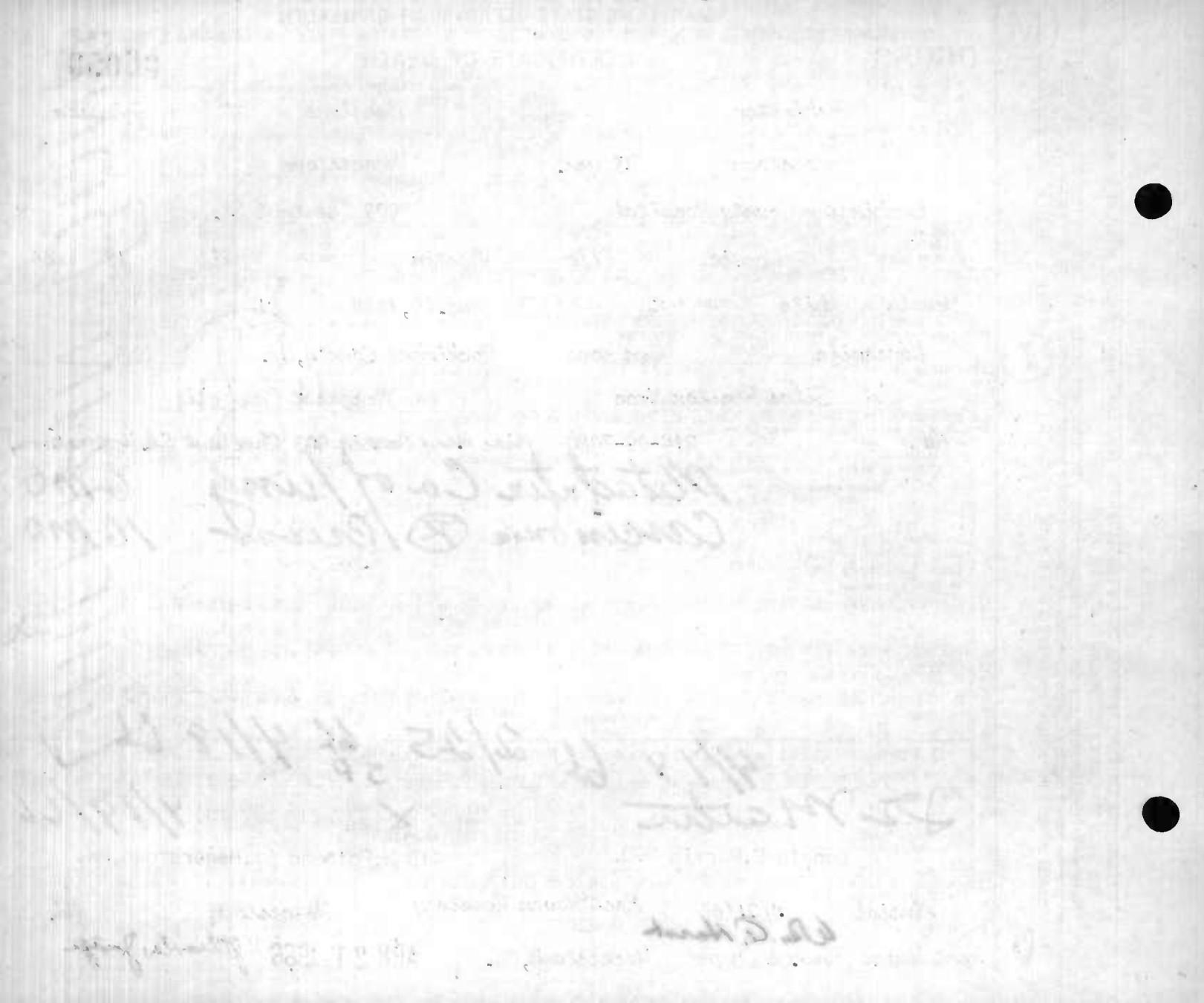
CERTIFICATE OF DEATH

06053

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Washington MARYLAND		a. STATE Maryland	b. COUNTY Washington
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Hagerstown		45 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
Washington County Hospital		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
79		21-1	
3. NAME OF DECEASED (Type or print)		First Nannie	Middle Ella
Last Martin		4. DATE OF DEATH April	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Own Home	
13. FATHER'S NAME Silas Preston Mace		11. BIRTHPLACE (County & State, or foreign country) Rockingham County, Va.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. 214-09-7080		17. INFORMANT Miss Mary Martin 903 Chestnut St. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line a, b, and c)		19. INTERNAL BETWEEN ONSET AND DEATH 6 mo	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  170X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)	
Carcinoma (R) Breast		16 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED while Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/18/66 to 4/18/66, that (I) (we) last saw the deceased alive on 4/18/66, and that death occurred 5 PM, from the causes and on the date stated above.		22b. DATE SIGNED 4/19/66	
22a. SIGNATURE Donald E. Martin M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Donald E. Martin M.D.		22d. ADDRESS 418 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/21/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR W.G. Harrold		25a. REC'D BY REGISTRAR APR 21 1966	
Rest Haven Funeral Chapel Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Charles J. Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06054

## CERTIFICATE OF DEATH

06051

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK MD.</b>			c. LENGTH OF STAY IN 1b <b>LIFE</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL 1</b>			d. STREET ADDRESS <b>HANCOCK MD.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOME</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>FRANK</b>	Middle <b>JAMES</b>	Last <b>MCCUSKER</b>	4. DATE OF DEATH Month <b>4.</b> Day <b>21</b> Year <b>1966</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3.9.1888</b>	9. AGE (In years last birthday) yrs. <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESTAURANT OP.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON COUNTY MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ABNER MCCUSKER</b>			14. MOTHER'S MAIDEN NAME <b>SARAH BRIDGES</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217.32.5423</b>		17. INFORMANT Address <b>MRS CORA R MCCUSKER RURAL 1 HANCOCK MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>4201</b> <i>Cardiac Arrest - Coronary</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO <i>Other arteriosclerotic</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) <b>Cardiovascular Disease</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Parkinsonism</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-20</b> , 19 <b>66</b> , to <b>4-21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-20</b> , 19 <b>66</b> , and that death occurred at <b>9 A.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Charles R. Wierer</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Charles R. Wierer M.D.</b>		22b. DATE SIGNED <b>238 E. Main St., Hancock</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4.25.66</b>		23c. NAME OF CEMETERY OR CEMETORY <b>ST. PETERS CATHOLIC</b>	
24. FUNERAL DIRECTOR <b>Howard J. Stone Howard Md</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 27 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

23

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

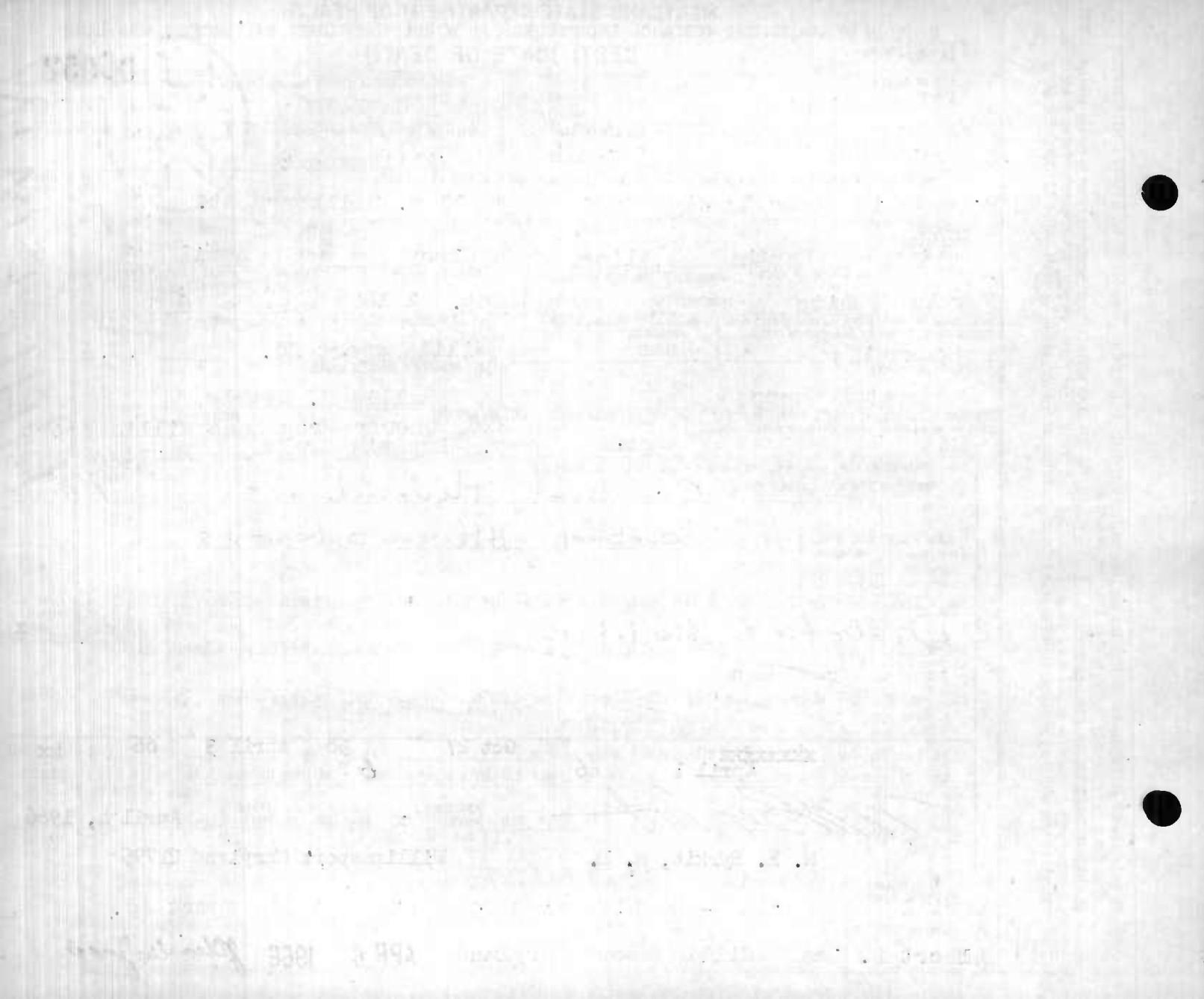
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06055

CERTIFICATE OF DEATH

06055

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 5 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Friendship Manor Nursing Home			
3. NAME OF DECEASED (Type or print)	First Martha	Middle Alice	Last Mc Elroy
4. DATE OF DEATH	Month April	Day 3	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2 1878
9. AGE (In years last birthday) 87 yrs.	10. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Williamsport Md.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Denton Shupp	14. MOTHER'S MAIDEN NAME Sallie V. Kimble		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT 226 Cherry Tree Lane Mrs. Virginia Drake	Address Williamsport Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Diabetics Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) attended the deceased from Oct 27, 1958, to April 3, 1966, that (I) last saw the deceased alive on April 1, 1966, and that death occurred at 5 P.M., from the causes and on the date stated above.			
22a. SIGNATURE M. E. Byrkit, M. D.		22b. DATE SIGNED April 4, 1966	
22c. PHYSICIAN'S NAME (Type)		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Williamsport Maryland 21795	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 6-66	
23c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		23d. LOCATION (City, town or county) (State) Williamsport Md.	
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport Maryland	
25a. REC'D BY REGISTRAR APR 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06056

CERTIFICATE OF DEATH

06053

1. PLACE OF DEATH  
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

WILLIAMSPORT

c. LENGTH OF STAY IN lb

3 YRS. 6 MOS.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WILLIAMSPORT SANITARIUM

3. NAME OF  
DECEASED  
(Type or print)

First  
ELIZABETH

Middle  
ANGELA

Last  
McGUIRE

4. DATE  
OF  
DEATH  
APRIL

Month  
30  
Day  
19  
Year  
66

5. SEX

FEMALE

6. COLOR OR RACE  
WHITE

7. MARRIED  
WIDOWED

NEVER MARRIED  
DIVORCED

8. DATE OF BIRTH  
AUG. 23, 1886

9. AGE (In years  
last birthday)  
79 yrs.

10. IF UNDER 1 YEAR  
Months  
Days  
Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOMEMAKER

10b. KIND OF BUSINESS OR  
INDUSTRY  
OWN HOME

11. BIRTHPLACE (County & State, or foreign country)

ALLEGANY CO., MARYLAND

12. CITIZEN OF WHAT  
COUNTRY  
U.S.A.

13. FATHER'S NAME

JOHN STAKEM

14. MOTHER'S MAIDEN NAME

ELLEN CULLEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MRS. PAUL WAGNER 13232 BELLEVUE ST.

SILVER SPRING, MD.

Address  
INTERVAL BETWEEN  
ONSET AND DEATH

7 days

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

491X

DUE TO

Conditions, If any, which  
gave rise to Immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO

(c)

Bilateral Lobular Pneumonia

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Advanced generalized arteriosclerosis & cerebral thrombosis

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 22, 1962, to Apr 30, 1966, that (I) (we) last  
saw the deceased alive on Apr 20, 1966, and that death occurred at 8 p.m. from the causes and on the date stated above.

22a. SIGNATURE

Edward W. Ditto III

22b. DATE SIGNED

5/2/1966

22c. PHYSICIAN'S  
NAME (Type)

EDWARD W. DITTO III M.D.

22d. ADDRESS

217 W. WASH. ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF  
MAY 3, 1966

23c. NAME OF CEMETERY OR CREMATORIUM  
ROSE HILL CEMETERY

23d. LOCATION (City, town or county) (State)  
HAGERSTOWN, MARYLAND

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

MAY 5 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



1 M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. File Pages 1, 2, and 3 in the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE										
Washington MARYLAND				W. Va.										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b Halfway, Hagerstown 1 day										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington County Hospital										
79				Berkeley Springs 85-3										
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
John William Miller						Miller	April	1	19	66				
5. SEX		6. COLOR OR RACE	7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS				
Male		white					Sept. 9, 1916	49 yrs.	Months 6	Days 22	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Laborer				Construction			Berkeley Springs, W. Va. USA							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME										
Not known				Delva Barker, (Living)										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			17. INFDRMNT	Address						
No				217-09-7279			James Miller							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INFERRED BETWEEN ONSET AND DEATH										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Crushing injury to chest										
9255				1-5 Min.										
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				Internal injuries										
(b)				DUE TO										
(c)				DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) trapped in 12 foot trench by cave-in										
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:00 a.m. 4-1-1966				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not White at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
							Street		Halfway Wash.		Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				22. DATE SIGNED 4-1-66										
ACTUAL SIGNATURE Edward W. DITTO III, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>										
EXAMINER'S NAME (Type) EDWARD W. DITTO III, M.D.				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (Specify)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
23b. DATE THEREOF 4/4/1966				Address (Street, city, town, or county) RURAL										
23c. NAME OF CEMETERY OR CREMATORIAL Union Chapel				23d. LOCATION (City, town, or county) (State)										
24. FUNERAL DIRECTOR Johnson Funeral Homes				Berkeley Springs, W. Va.										
Johnson Funeral Homes				25a. RECEIVED BY REGISTRAR APR 4 1966										
Berkeley Spgs. W. Va.				25b. REGISTRAR'S SIGNATURE Charles Judge										

... secondo piano, dove la luce  
... delle veline sarebbe meno intol-

abile. Tuttavia, il tutto è già

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			06058			06055		
1. PLACE OF DEATH a. COUNTY			WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE			MARYLAND			b. COUNTY			WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			HAGERSTOWN LIFE			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			WASHINGTON COUNTY HOSPITAL			1600 EVELYN AVE.			21-1											
3. NAME OF DECEASED (Type or print)			First VIRGINIA MIDDLE ALBERTA LAST MITCHELL			4. DATE OF DEATH			APRIL 8 1966			Month Day Year								
5. SEX			6. COLOR OR RACE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday)			IF UNDER 1 YEAR					
FEMALE			WHITE			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			3/29/1912			54 yrs.			MONTHS DAYS HOURS MIN.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?											
HOUSEWIFE			HOME			MATYLAND			U.S.A.											
13. FATHER'S NAME			BENJAMIN POFFENBERGER			14. MOTHER'S MAIDEN NAME			ANNA REYNOLDS											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address			HAGERSTOWN MD.								
NO			214-09-4623			MR. ARTHUR D. MITCHELL														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												2 day								
330X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.												Central Aneurysm								
OUE TO (b) cause (a), stating the underlying cause last.												Subarachnoid hemorrhage 2 day								
OUE TO (c)																				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												none								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									19. WAS AUTOPSY PERFORMED?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)											
19																				
21. I certify that (I) (this hospital) attended the deceased from 4/6, 1966, to 4/8, 1966, that (I) (we) last saw the deceased alive on 4/8, 1966, and that death occurred at 345P.M. from the causes and on the date stated above.																				
22a. SIGNATURE			Robert V. Campbell			M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			4/11/66					
22c. PHYSICIAN'S NAME (TYPE)			Robert V. Campbell			22d. ADDRESS			HAGERSTOWN MD.											
23a. BURIAL, CREMATION, BURIAL (Specify)			23b. DATE THEREOF 4/11/66			23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.			23d. LOCATION (City, town or county) (State)											
									HAGERSTOWN MD.											
24. FUNERAL DIRECTOR			ADDRESS			25a. REG'D BY REGISTRAR APR 12 1966			25b. REGISTRAR'S SIGNATURE											
W. J. Ferment, Hagerstown Md.						DATE			Charles Judge											
VR A15 (4) 20M 1/65																				

2200

СИРИЯ

КОРОЛІВСТВО

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СІРІЯ 1961

АНГЕЛІЧНА СТУДІЯ СОВІЕТСЬКИХ

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

06059

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06056

1.. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 420 Fremont St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-1	
d. STREET ADDRESS 420 Fremont St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First EDITH Middle VIOLA Last MONG		4. DATE OF DEATH Month April 16, Year 1966	
5. SEX female COLOR OR RACE white		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. B. DATE OF BIRTH Sept. 28, 1920		8. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank L. Smith		14. MOTHER'S MAIDEN NAME Bertha Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no; or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Richard Smith, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Instant	
4201 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.			
(b) Chronic Rheumatic Heart Disease		Long standing	
DUE TO			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 4-18-66			
Address (Street, city, town, or county) Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-18-66	
23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE APR 20 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

06060

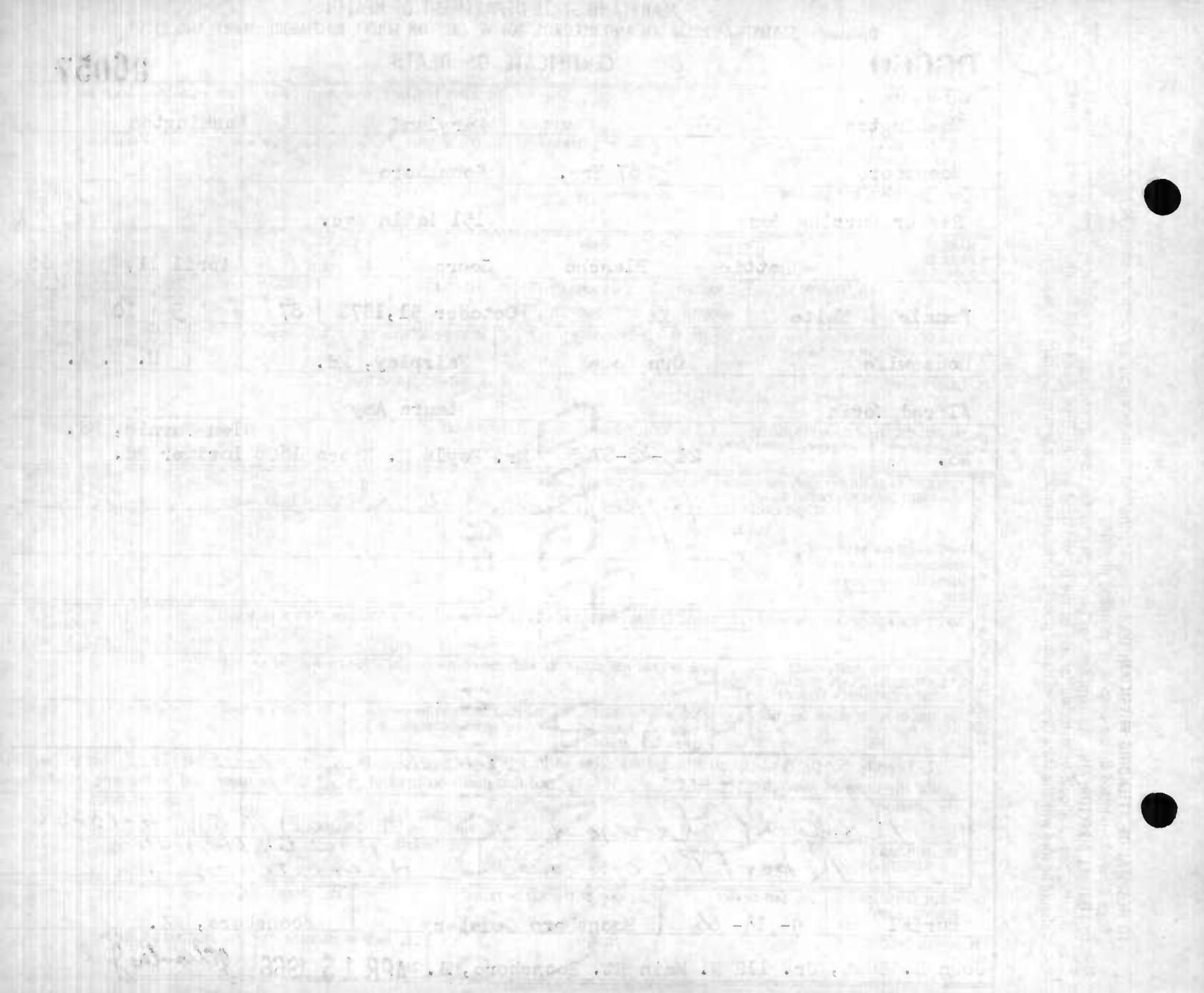
## CERTIFICATE OF DEATH

06057

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		c. LENGTH OF STAY IN lb <b>67 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		d. STREET ADDRESS <b>131 Lakin Ave.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reeder Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Hattie</b>		First <b>Hattie</b>	Middle <b>Blanche</b>	Lost <b>Moore</b>	4. DATE OF DEATH <b>April 11, 1966</b>	Month <b>April</b>	Doy <b>11</b>	Year <b>1966</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 31, 1878</b>	9. AGE (In years lost birthday) <b>87 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. Days <b>10</b>	Hours <b>10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Fairplay, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alfred Morin</b>				14. MOTHER'S MAIDEN NAME <b>Laura Amy</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>215-48-8765</b>		17. INFORMANT <b>Glen Burnie, Md.</b>			
Mr. Doyle H. Moore 1608 Lorimer Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyperarterive CV Disease</b> DUE TO 4431 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)								INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4-11-66</b> , 19 <b>66</b> , to <b>4-11-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-11-66</b> , and that death occurred at <b>5 P.M.</b> from causes and on the date stated above.								
22a. SIGNATURE <i>Robert P. Conrad</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-13-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad, MD</b>		22d. ADDRESS <b>137 W. Washington Hagerstown, 7772</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-14-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Boonsboro Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>APR 15 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
06061				06058											
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Washington							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 week				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS #2 S. Vermont St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Lenora	Middle Irene	Last Morgan	4. DATE OF DEATH April	Month 20	Day 19	Year 66							
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22 1901	9. AGE (in years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS Days 29	Hours 0	Min. 0						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) Williamsport Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A						
13. FATHER'S NAME David W. Young				14. MOTHER'S MAIDEN NAME Anna Little											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. none			17. INFORMANT #2 S. Vermont St. Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493 X DUE TO Pneumonia															
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Con polmonate															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Hour a.m. p.m.		Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) this hospital attended the deceased from Jan 1962 to April 20 1966 that (I) (we) last saw the deceased alive on April 19 1966, and that death occurred at 12:00 M, from the causes and on the date stated above.															
22a. SIGNATURE M.E. Byrkit															
22b. DATE SIGNED 4-20-66															
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS Williamsport Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 22-66				23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery				23d. LOCATION (City, town or county) (State) Williamsport Md.					
24. FUNERAL DIRECTOR Jennie E. Leaf		ADDRESS Williamsport Md.				25a. REC'D BY REGISTRAR APR 25 1966				25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 20M 1/65															

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06062

CERTIFICATE OF DEATH

06059

## 1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Maugansville

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Maugansville, Md.

3. NAME OF  
DECEASED  
(Type or print)

First DANIEL

Middle MARK

Last MOWEN

5. SEX

6. COLOR OR RACE Male White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 4. DATE  
OF  
DEATH April 3

Month Year 1966

Day

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Pipe Fitter

W.M.D.R.R.

8. DATE OF BIRTH Aug. 28, 1886

9. AGE (in years last birthday) 79 yrs.

IF UNDER 1 YEAR Months Days Hours Min.

13. FATHER'S NAME

Martin L. Mowen

11. BIRTHPLACE (County &amp; State, or foreign country)

Wash. Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. 705-10-6602

17. INFORMANT Mrs. Estella Mowen - Maugansville, Md.

14. MOTHER'S MAIDEN NAME

Sarah Rebecca Hartman

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4200 DUE TO

Conditions, If any, which gave rise to immediate cause (a), stating the

(b) DUE TO

cause (a), stating the underlying cause last.

(c) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

years.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Chronic bronchitis

19. WAS AUTOPSY PERFORMED?

YES  ND 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While at work  Not While at work  20e. PLACE OF INJURY (Home, farm, factory, street, Office bldg., etc.) 20f. (City or town) (County) (State)

p.m.

19

21. I certify that (I) (this hospital) attended the deceased from Jan 22, 1966, to April 3, 1966, that (I) (we) last saw the deceased alive on Jan 29, 1966, and that death occurred at 7:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE SIGNED

4/4/66

M.D. ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS. 

22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS

Hagerstown, Maryland

159 West Washington St.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL

Burial 4/5/66 Broadfording Cem. Washington Co., Md.

24. FUNERAL DIRECTOR ADDRESS

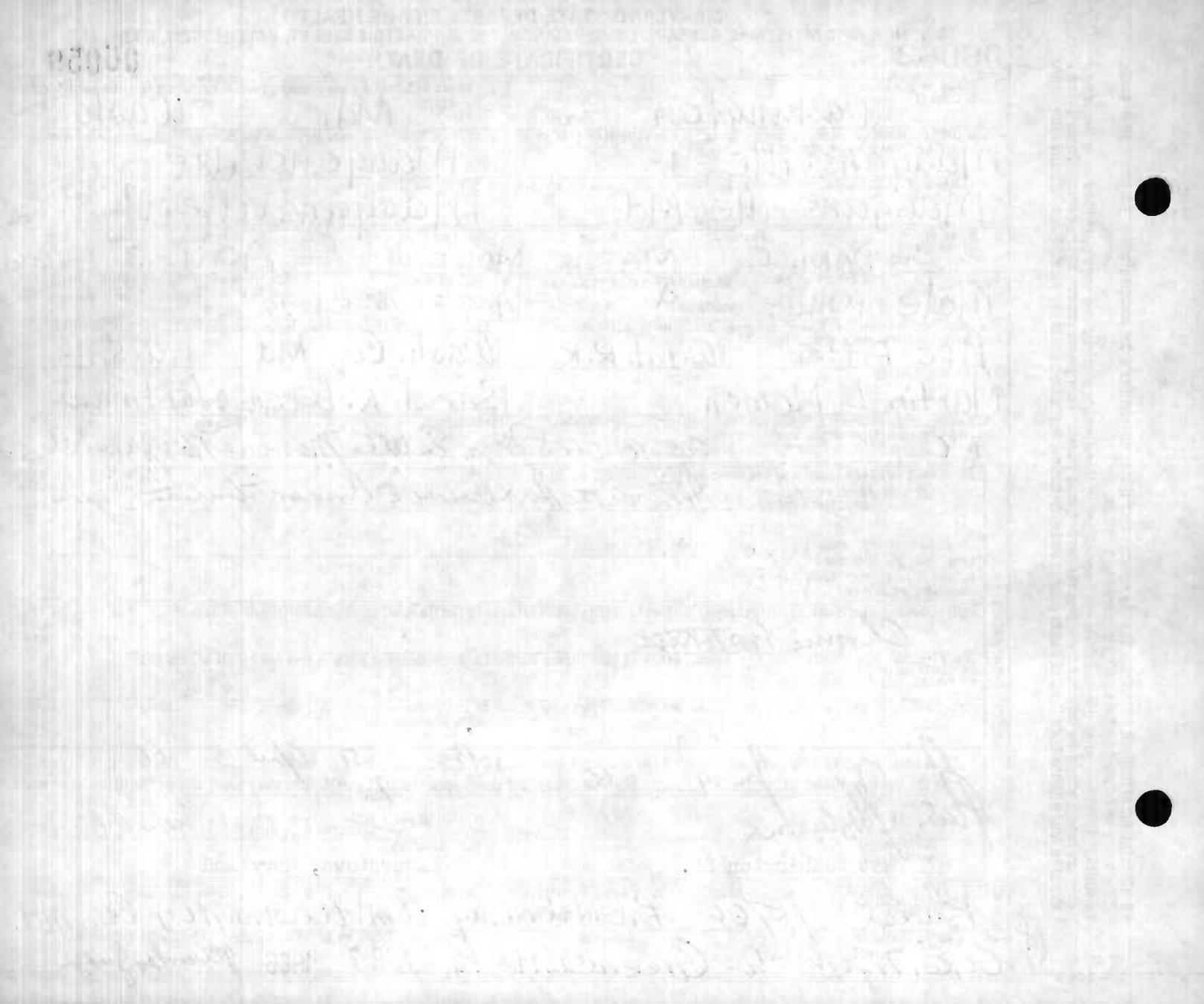
A.E. Minnoch - Greencastle, Pa.

25a. REC'D BY REGISTRAR DATE APR 7 1966 25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



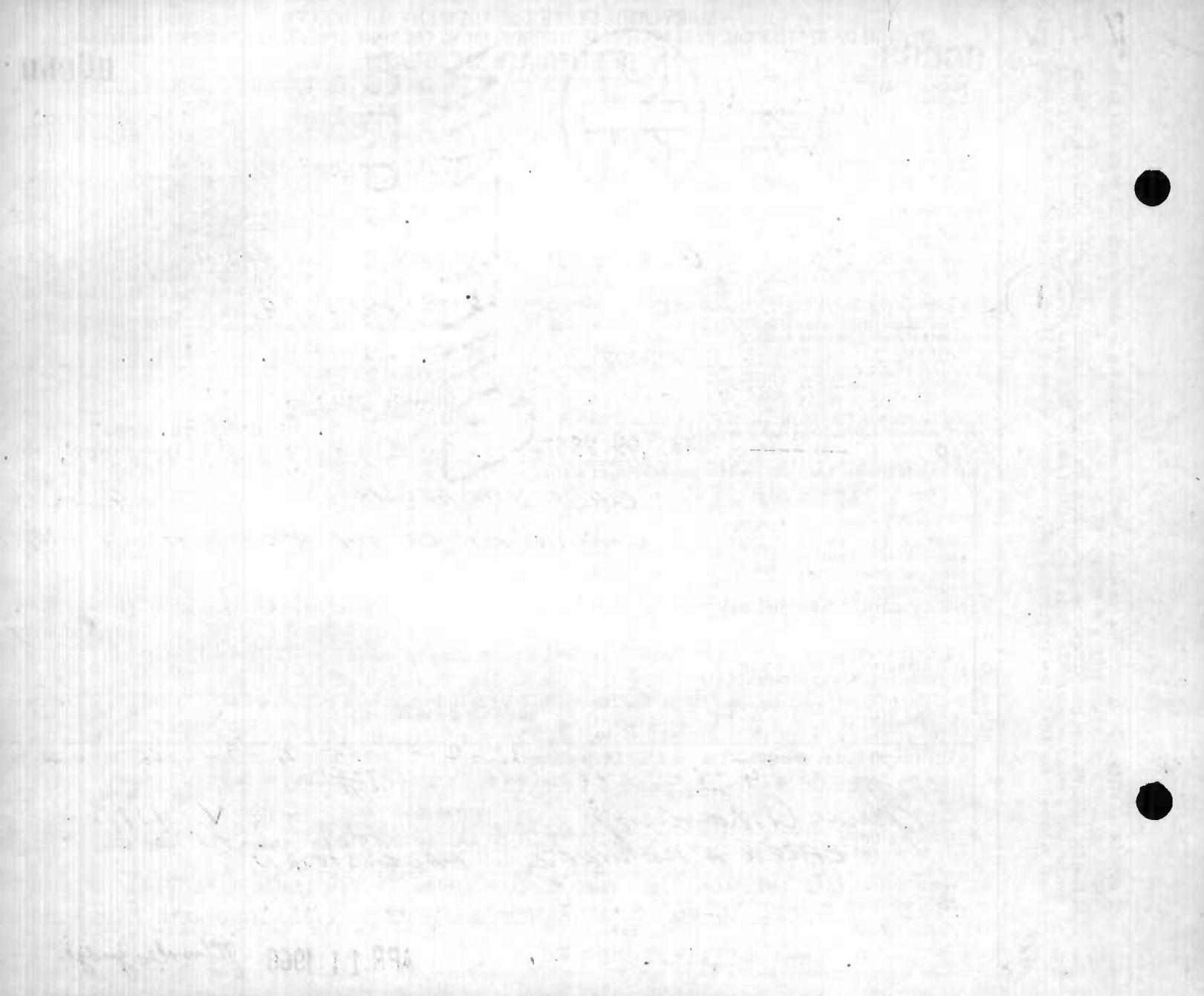
*1* M  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

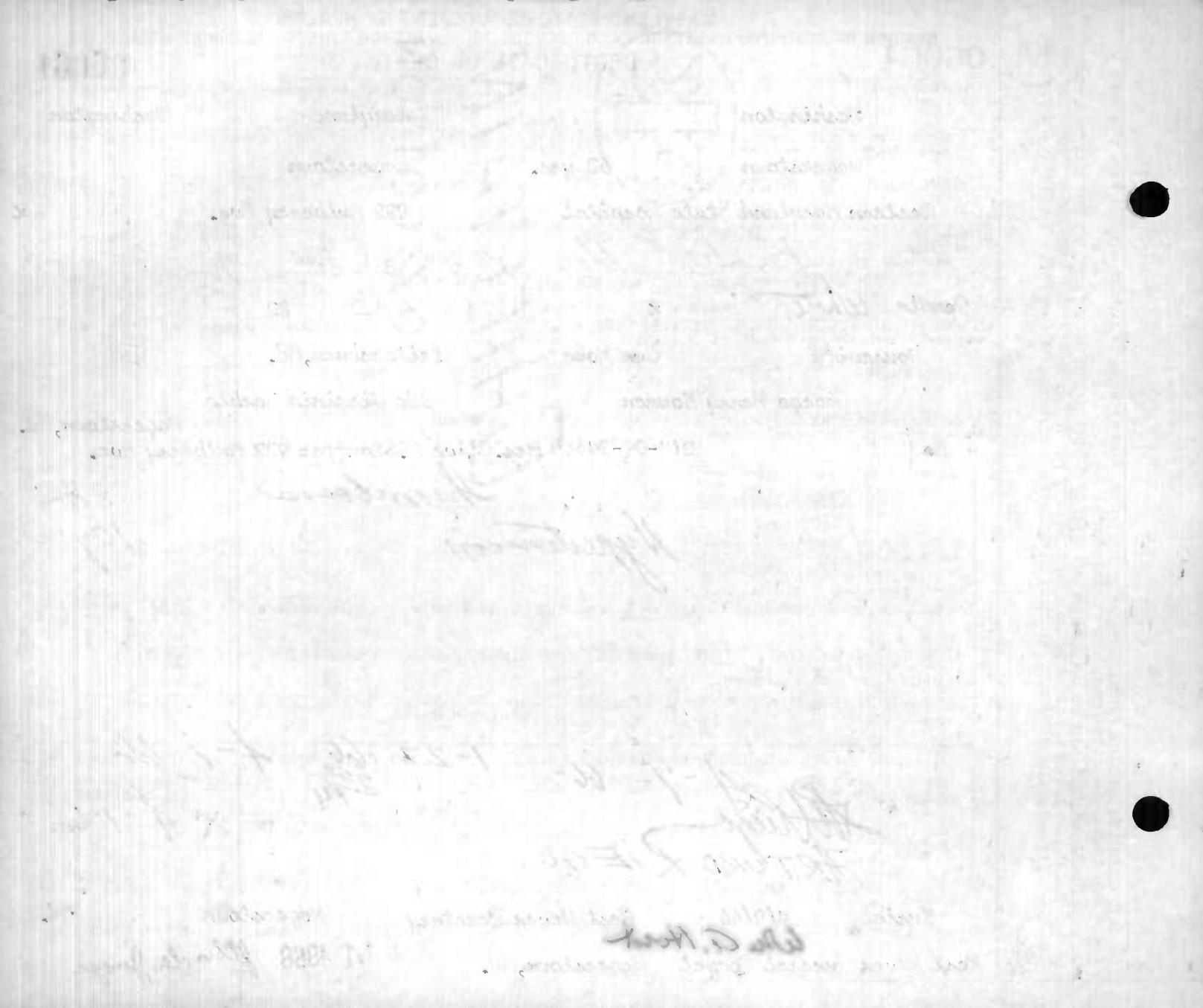
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06063 06063

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 month			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital					
3. NAME OF DECEASED (Type or print)	First JOHN	Middle GODDARD	Last MURRAY		
4. DATE OF DEATH APRIL 7 1966	Month Oay Year				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-8-1886	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Tannery		11. BIRTHPLACE (County & State, or foreign country) Williamsport Md.	
13. FATHER'S NAME John Murray		14. MOTHER'S MAIDEN NAME Sarah Miller		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 097 2352		17. INFORMANT 29 E. Church St. Address Miss. Aurelia Murray Williamsport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  151X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)  CARCINOMATOSIS CARCINOMA OF THE STOMACH INTERVAL BETWEEN ONSET AND DEATH 4 mos 7 mos					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-21-, 1965, to 4-7-, 1966, that (I) (we) last saw the deceased alive on 4-6-, 1966, and that death occurred at 743 M, from the causes and on the date stated above.					
22a. SIGNATURE <i>Eugen A. Ramirez</i>		22b. DATE SIGNED 4/7/66			
22c. PHYSICIAN'S NAME (Type) EUGEN A. RAMIREZ		22d. ADDRESS 1560 Park Ave. HAGERSTOWN			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 10-66		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.		23d. LOCATION (City, town or county) (State) Williamsport Maryland			
		25a. REC'D BY REGISTRAR APR 11 1966			
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

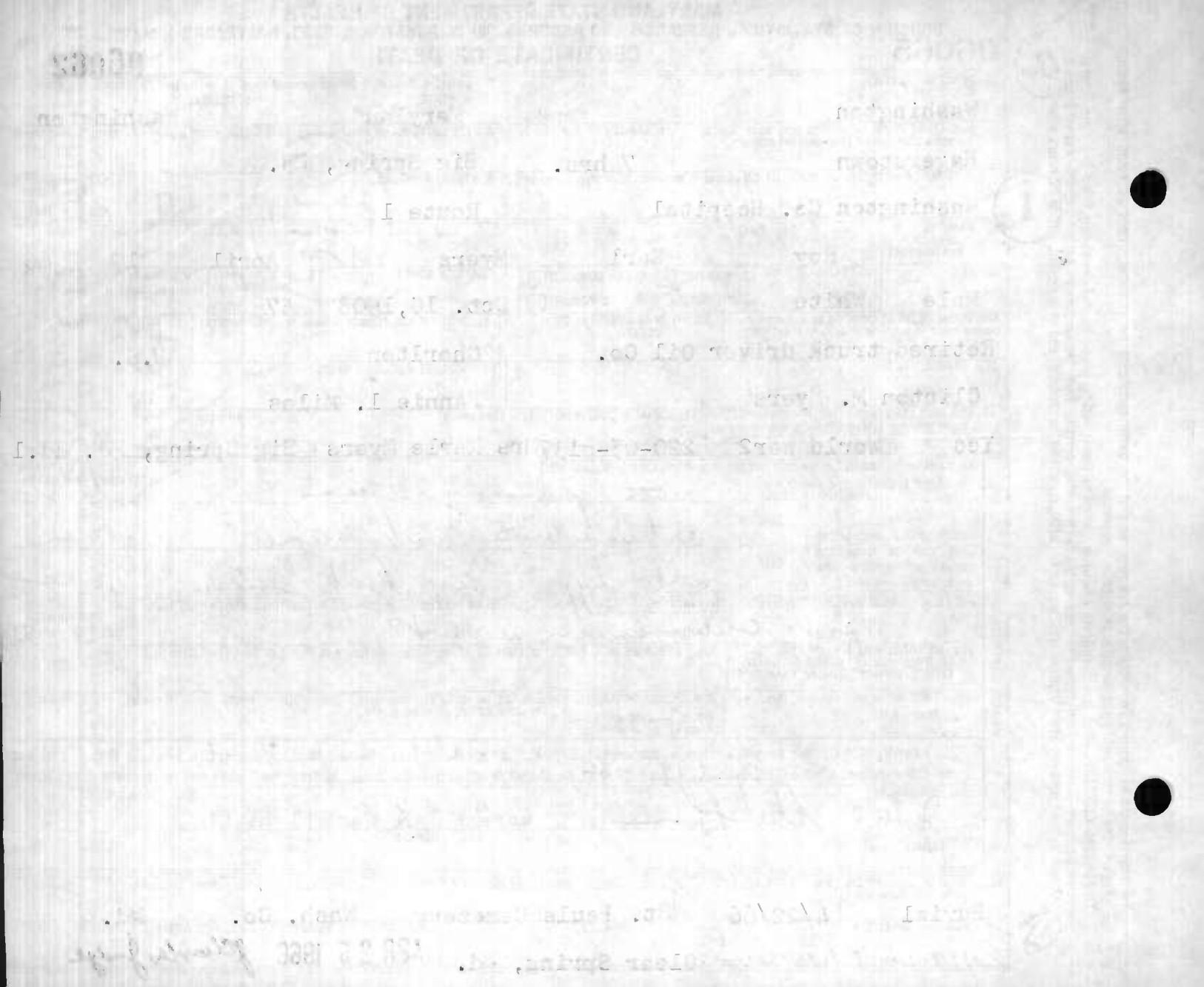
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

18 06065 06062

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>7 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Spring, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>Route 1</b>	
3. NAME OF DECEASED (Type or print) <b>Roy Earl Myers</b>		First <b>Roy</b> Middle <b>Earl</b> Last <b>Myers</b>	4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>19 66</b>
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 10, 1908</b> 9. AGE (in years last birthday) <b>57 yrs.</b> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Charlton</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Clinton M. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Fannie L. Miles</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>220-05-6137</b> 17. INFORMANT <b>Mrs Merle Myers</b> Address <b>Big Spring, Md., Rd. 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
4200 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> years (c) <b>and hypertensive heart disease</b> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>post cerebrovascular accident</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. INJURY OCCURRED <b>While at work</b> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wash Co.</b> 20f. (City or town) <b>Wash Co.</b> (County) <b>Md.</b> (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 19, 1964</b> to <b>death</b> , 19, that (I) (we) last saw the deceased alive on <b>April 19, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>John E. Hanmer</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/22/66</b> 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Pauls Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Wash Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Margaret Rowland</b>		25a. REC'D BY REGISTRAR <b>APR 25 1966</b>	25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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06066

## CERTIFICATE OF DEATH

06063

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>½ Hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>			d. STREET ADDRESS <b>433 W. Franklin St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Cinty Sue Overcash</b>			First	Middle	Last	4. DATE OF DEATH Month Day Year <b>April 9 1966</b>		
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <b>Never</b>	NEVER MARRIED DIVORCED <b>None</b>	8. DATE OF BIRTH <b>April 9, 1966</b>	9. AGE (In years last birthday) yrs. <b>32</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>0 0 0 0</b>	IF UNDER 24 HRS. <b>0 0 0 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lee S. Overcash</b>			14. MOTHER'S MAIDEN NAME <b>Linda Lee Bean</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>Lee S. Overcash 433 W. Franklin St. Hagerstown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary atelectasis</b> DUE TO <b>7620</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <b>6:30 AM 4/9/66</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>4/9/66</b>	(County) <b>19</b>	(State) <b>19</b>
21. I certify that (I) (this hospital) attended the deceased from <b>4/9/66</b> , '19, to <b>4/8/66</b> , '19, that (I) (we) last saw the deceased alive on <b>6:30 AM 4/9/66</b> and that death occurred at <b>6:30 AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Harold H. Gist</b>			M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <b>11 April 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harold H. Gist, M. D.</b>			22d. ADDRESS <b>214 N. Potomac St. Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 11/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>		
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>				ADDRESS <b>Hagerstown, Md.</b>	25a. REC'D BY REGISTRAR <b>APR 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>jCharles Judge</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

06067

**CERTIFICATE OF DEATH**

06064

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1.		PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
		Washington MARYLAND		a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Hagerstown		27 yrs.		Hagerstown 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
Washington County Hospital 79		1775 Linda Drive		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Roy	Middle Clayton	Last Pitcock	4. DATE OF DEATH April 8 1966
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1894	9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (County & State, or foreign country) Chewsville, Md.	
13. FATHER'S NAME Thomas A. Pitcock		14. MOTHER'S MAIDEN NAME Annie E. Berger		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8709		17. INFORMANT Mrs. R.C. Pitcock 1775 Linda Dr., Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  443 X		anorectal Hemorrhoids 1 day			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.  (b)		Hyperplastic Colitis - Varicose Veins 10/9/65			
DUE TO  (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Heart Block.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1966, to Aug. 8, 1966, that (I) (we) last saw the deceased alive on Aug. 16, 1966, and that death occurred at 7A M, from the causes and on the date stated above.		22b. DATE SICKED 9/8/66			
22a. SIGNATURE J.H. Beccley		22b. DATE SICKED 9/8/66			
22c. PHYSICIAN'S NAME (Type) J.H. Beccley		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	
24. FUNERAL DIRECTOR		ADDRESS		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
Rest Haven Funeral Chapel		Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 13 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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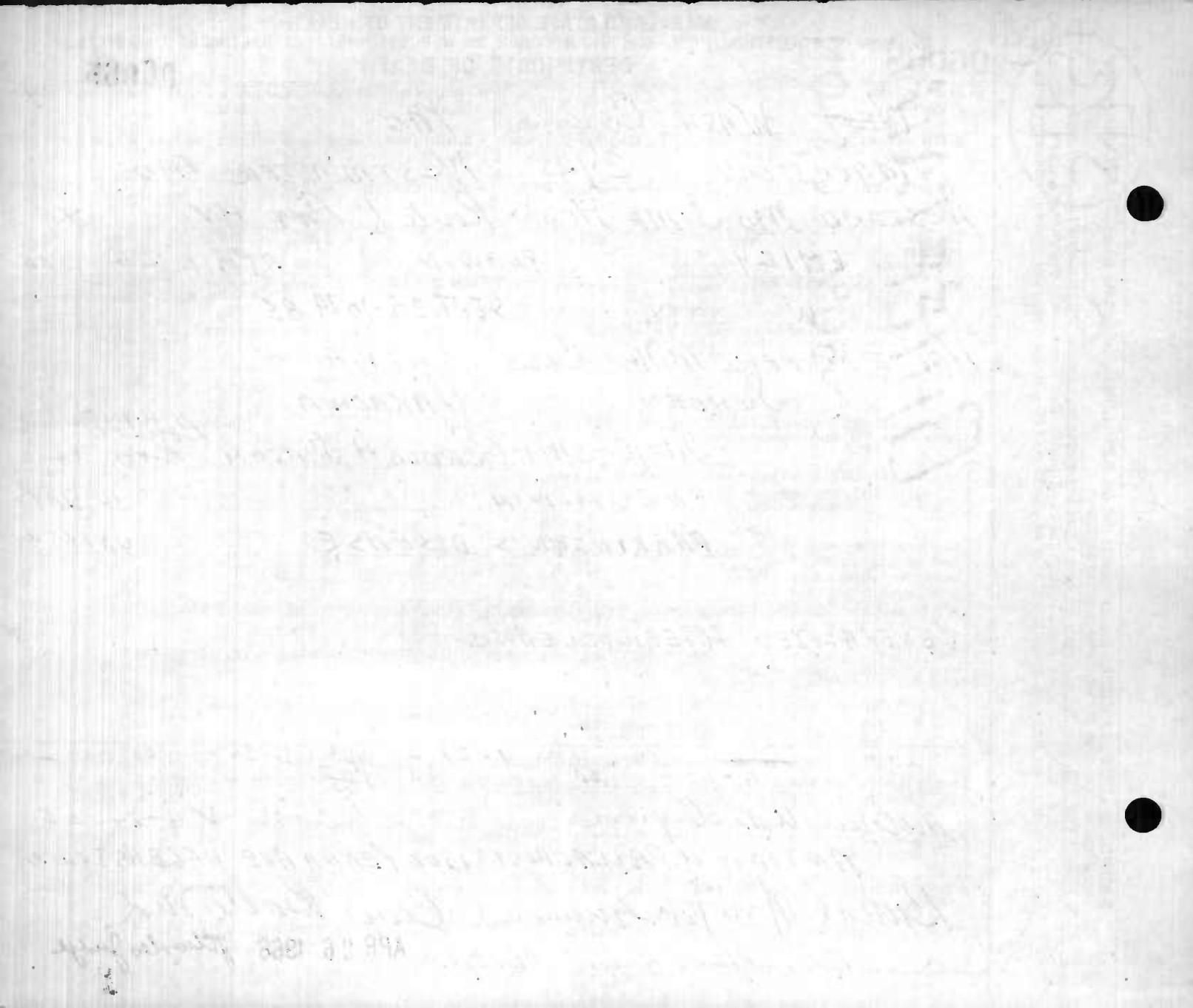
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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10. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
<i>WEST WASH Co MARYLAND</i>		<i>Md.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town)	
<i>HAGERSTOWN.</i>		<i>3 yrs.</i>	
3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
<i>WESTERN MD STATE HOSP.</i>		<i>Route 6 Box 4Y</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>EMILY</i>		<i>PLAWIN</i>	<i>4. DATE OF DEATH APRIL 24 1966</i>
5. SEX		6. COLOR DR RACE	
<i>F.</i>		<i>W.</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
<i>WIDDOWED <input checked="" type="checkbox"/></i>		<i>SEPT. 25 - 1879 86 yrs.</i>	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
<i>111</i>		<i>IF UNDER 24 HRS.</i>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>LATVIA.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>HOUSEKEEPER. Miller Bros</i>		<i>Unknown.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>NO</i>		<i>16-10-5449.</i>	
17. INFORMANT		Address	
<i>Gordon H. Schoen</i>		<i>Westminster Route 6 Box 42</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>10 DAYS</i>	
<i>PNEUMONIA</i>			
350X			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>PARKINSON'S DISEASE</i>	
		DUE TO (c)	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>GENERALIZED ATHEROSCLEROSIS.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
<i>NO</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<i>19</i>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
<i>at work</i>			
21. I certify that (I) attended the deceased from <i>1-21- 1963</i> to <i>4-24- 1966</i> , that (I) was last seen the deceased alive on <i>4-23- 1966</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.		22b. DATE SIGNED	
<i>Antonio U. Pallacrosi</i>		<i>4-24-66</i>	
22a. SIGNATURE		22d. ADDRESS	
<i>Antonio U. Pallacrosi</i>		<i>1500 PENNA AVE HAGERSTOWN</i>	
22c. PHYSICIAN'S NAME (Type)		23a. BURIAL CREMATION, DATE THERED REMOVAL (specify)	
<i>ANTONIO U. PALLACROSI</i>		<i>23b. NAME OF CEMETERY OR CREMATORI</i>	
		<i>23c. LOCATION (City, town or county) (State)</i>	
		<i>Baltimore Md</i>	
24. FUNERAL DIRECTOR		25a. REC'D. BY REGISTRAR	
		<i>APR 26 1966</i>	
		<i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06069		16066											
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
Washington, MARYLAND					a. STATE Maryland b. COUNTY Prince George's								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) mt Rainier								
c. LENGTH OF STAY IN lb 10 mo.					d. STREET ADDRESS 3714 - 35 st								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Edward	Last Porter	4. DATE OF DEATH	Month 4	Day 25	Year 1966					
5. SEX M		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1909	9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Dey 0	12. IF UNDER 24 HRS Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician			10b. KIND OF BUSINESS OR INDUSTRY Building			11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ??			14. MOTHER'S MAIDEN NAME ??										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 167-09-1173			17. INFORMANT Flora Porter			Address same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO ASPIRATION PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH UNKNOWN													
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CEREBRAL THROMBOSIS 14 YEARS (c) DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CIRRHOSIS OF THE LIVER & MALNUTRITION 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) 8-4, 1966 to 4/25, 1966		(County) 1966		(State) 1966	
21. I certify that (I) (this hospital) attended the deceased from 8-4, 1966 to 4/25, 1966 that (I) (we) last saw the deceased alive on 4/25, 1966, and that death occurred at 5th M, from the causes and on the date stated above.		22a. SIGNATURE Efren A Ramirez DATE SIGNED 4/26/66											
22b. PHYSICIAN'S NAME (Type) EFREN RAMIREZ		22d. ADDRESS 1509 parn. ave, Hyattsville, Md.		22c. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 29, 1966		23c. NAME OF CEMETERY OR CREMATORIAL 3rd Lincoln Cemetery		23d. LOCATION (City, town or county) Colmar Manor		(State) Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR MAY 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							
F. Gasch's Sons, Hyattsville, Md.		DATE											



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

060-20 116-67

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>											
3. NAME OF DECEASED (Type or print) <b>LAWRENCE THOMPSON</b>		First <b>LAWRENCE</b>	Middle <b>THOMPSON</b>	Last <b>POWELL</b>	4. DATE OF DEATH <b>APRIL 15 1966</b>	Month <b>APRIL</b>	Day <b>15</b>	Year <b>1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/1893</b>	9. AGE (in years last birthday) <b>73 yrs.</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS. <b>Days</b>	12. IF UNDER 24 HRS. <b>Hours</b>	13. IF UNDER 24 HRS. <b>Min.</b>		
14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED DEPT. MGR</b>			14b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>		14c. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		14d. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
14e. FATHER'S NAME <b>JOHN E. POWELL</b>		14f. MOTHER'S MAIDEN NAME <b>NETTIE THOMPSON</b>		14g. ADDRESS <b>HAGERSTOWN MD.</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W.#1 214-09-7631</b>		17. INFIRMITY <b>MRS. RUTH BORDWELL</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Myocardial infarction</i> 7 days									
4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		<i>Coronary sclerosis</i> yrs									
DUE TO (b)		<i>Generalized arterosclerosis</i> yrs -									
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Diabetes, osteoarthritis</i>								19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19											
21. I certify that (I) (this hospital) attended the deceased from <i>26 Aug 1959</i> , to <i>date 19</i> , that (I) (we) last saw the deceased alive on <i>15 Apr 1966</i> , and that death occurred at <i>67</i> M, from the causes and on the date stated above.										22b. DATE SIGNED <i>18 Apr 66.</i>	
22a. SIGNATURE <i>Richard T. Binford</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <i>Richard T. Binford</i>								22d. ADDRESS <i>1135 Belmont Ave, Hagerstown, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE THEREOF <b>4/18/66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>ROSE HILL CEM.</b>		23d. LOCATION (City, town or county) <b>HAGERSTOWN</b>		(State) <b>MD.</b>			
24. FUNERAL DIRECTOR <i>W.J. Horowitz, Hagerstown, Md.</i>		ADDRESS		25a. RECEIVED BY REGISTRAR <b>APR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06071

## CERTIFICATE OF DEATH

06068

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Boonsboro		c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rd. # 1 Boonsboro		e. STREET ADDRESS Rd. # 1			
3. NAME OF DECEASED First BLANCHE Middle BETTY Last PRICE		4. DATE OF DEATH April 20 1966			
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1863 Nov. 17, 1864		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home			
13. FATHER'S NAME Wilson Carrier		14. MOTHER'S MAIDEN NAME Rebecca Hoffman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none			
17. INFORMANT Millard Price		Address Hagerstown. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to death 19, thot (I) (we) lost saw the deceased alive on 4-11-1966, and that death occurred at 12:34 A.M. from causes and on the date stated above.					
22a. SIGNATURE Robert F. Keade		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4-20-66		
22c. PHYSICIAN'S NAME (Type) ROBERT F. KEADE		22d. ADDRESS Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/22/66		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME		ADDRESS Hagerstown, Md.		25a. REC'D. BY REGISTRAR APR 25 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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executed within 24 hours after death.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that t

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

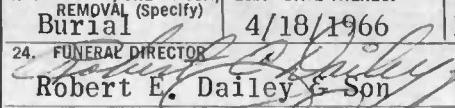
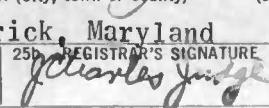
**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## **CERTIFICATE OF DEATH**

96060

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			b. COUNTY Frederick		
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Maryland State Hospital			d. STREET ADDRESS 434 West South Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First WALTER	Middle WILFRED	Last REEDER	4. DATE OF DEATH APRIL 15 1966	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/97	9. AGE (in years last birthday) XX 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Mechanic		11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Nelson Reeder			14. MOTHER'S MAIDEN NAME Cora Twenty		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-10-5643		17. INFORMANT Mr. Leonard F. Reeder 329 N. Bentz St. Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 massive pulmonary Embolism DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
(b) Congestive heart failure DUE TO			3 weeks		
(c) Arteriosclerotic heart disease DUE TO			Not known		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Thrombosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-3-, 1966, to 4-15-, 1966, that (I) (we) last saw the deceased alive on 4-15-1966, and that death occurred at 5:45 AM, from the causes and on the date stated above.					
22a. SIGNATURE 			22b. DATE SIGNED 4-15-66		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1500 Penna. Ave. - Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/1966		23c. NAME OF CEMETERY OR CREMATORIAL Rocky Springs Cemetery	
24. FUNERAL DIRECTOR 		ADDRESS Frederick, Md.		25a. REC'D. BY REGISTRAR APR 18 1966	
Robert E. Dailey & Son				25b. REGISTRAR'S SIGNATURE 	

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

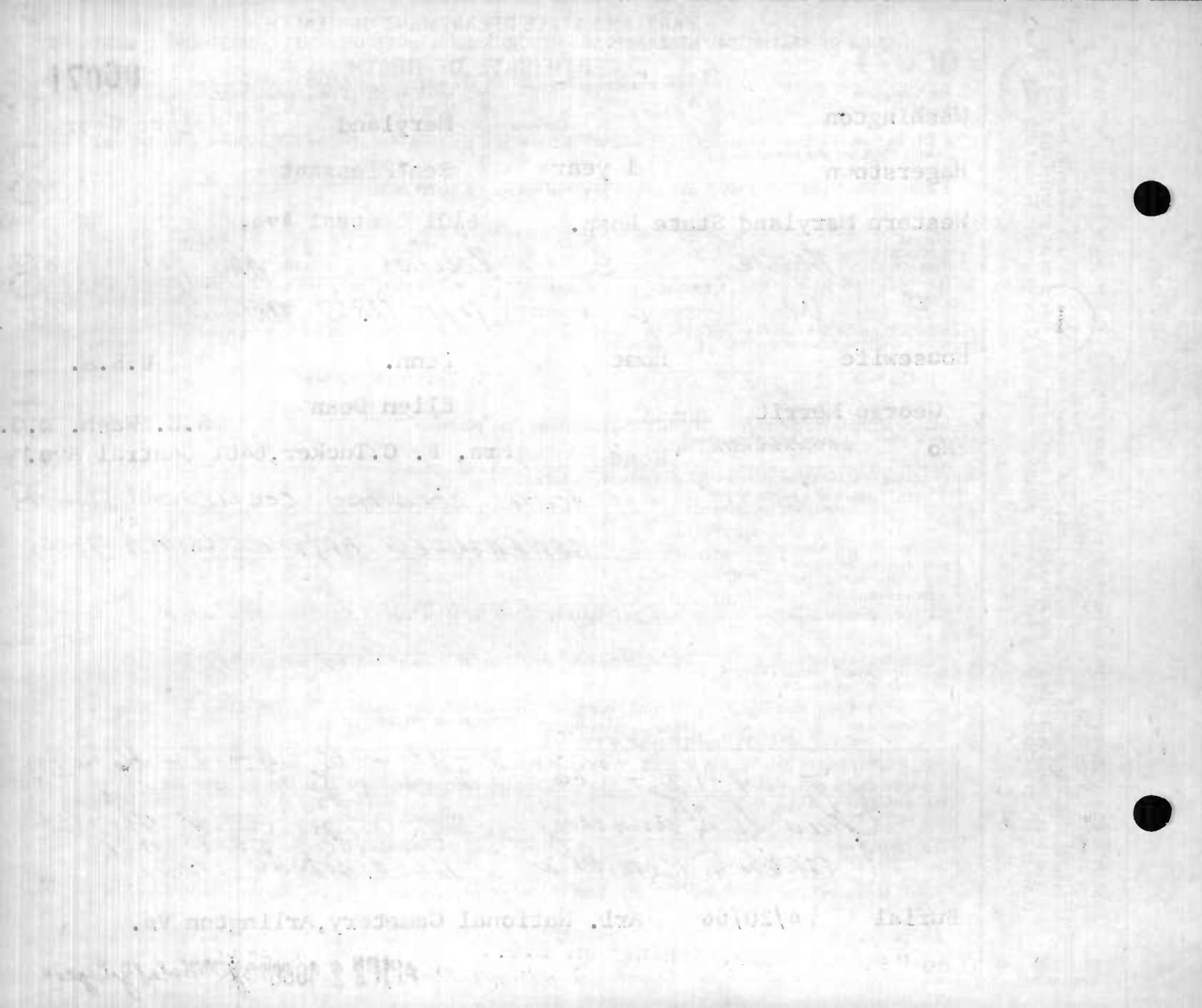
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Brownsville</b>				c. LENGTH OF STAY IN 1b <b>Minutes</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>State Rt. 65</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Knoxville</b>							
								d. STREET ADDRESS <b>Box 261</b>			
								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
								21-1			
3. NAME OF DECEASED (Type or print) <b>Vera Van Rensselaer Rhinaman</b>				4. DATE OF DEATH <b>April 16, 1966</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 12, 1921</b>		9. AGE (In years last birthday) <b>44 yrs.</b>		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shaper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lens Grinding</b>				11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W. Va.</b>			
13. FATHER'S NAME <b>Charles H. Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Van R. Wilson</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>235-28-3359</b>				17. INFORMANT <b>Mrs. Peggy L. Goetz Rfd. 1 Harpers Ferry,</b> Address <b>W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of skull</b> 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)								INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Speeding car, swerved from road striking tree stump.</b>											
20c. TIME OF INJURY Month, Day, Year <b>10:17 a.m. April 16, 1966</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State R#67</b>		20f. (City or town) (County) (State) <b>Gaithersburg Wash. Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>4-18-66</b>			
EXAMINER'S NAME (Type) <b>E. W. DITTO, JR., M. D.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4-19-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>New Narbaum Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Martinsburg, W. Va.</b>			
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				ADDRESS				25a. REC'D BY REGISTRAR <b>APR 21 1966</b>		25b. REGISTRAR'S SIGNATURE 	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 3, 7, 13, 14, 15, G-76 mm 5/12/66 06074 06071											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				a. STATE Maryland b. COUNTY Prince George							
c. LENGTH OF STAY IN 1b 1 year				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant 16-2							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hosp.				d. STREET ADDRESS 6401 Central Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BESSIE		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877 10/10/1857	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. M. BIRTHPLACE (County & State, or foreign country) Penn.			
13. FATHER'S NAME George Merrit				14. MOTHER'S MAIDEN NAME Merrill				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. F. C. Tucker, 6401 Central Ave. Adm. E. Wash. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO ACUTE coronary occlusion INTERVAL BETWEEN ONSET AND DEATH MINUTES Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO GENERALIZED ARTERIOSCLEROSIS 48005. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-30-1965, to 4-17-1966, that (I) (we) last saw the deceased alive on 4-17-1966, and that death occurred at 12:35 P.M., from the causes and on the date stated above.											
22a. SIGNATURE ERREN A. RAMIREZ				22b. DATE SIGNED 4/17/66							
22c. PHYSICIAN'S NAME (Type) ERREN A. RAMIREZ				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22d. ADDRESS 1500 PENN. AVE. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/20/66				23c. NAME OF CEMETERY OR CREMATORIAL Arl. National Cemetery, Arlington Va.			
24. FUNERAL DIRECTOR Lee Funeral Home, Washington, D.C.				ADDRESS				25a. REC'D BY REGISTRAR APR 22 1966 25b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**1** **H** **M** **1**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**06075**

**CERTIFICATE OF DEATH**

**06072**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>88 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>239 S. Locust St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>239 S. Locust St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>MARTHA</b>	Middle <b>ROSENA</b>	Last <b>SCHENSKY</b>	4. DATE OF DEATH <b>April 25 1966</b>	Month <b>April</b>	Day <b>25</b>	Year <b>1966</b>	
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 24, 1877</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Charles Peters</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Gilbert Schensky</b>			Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>								INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>	
DUE TO (b) <b>Arteriosclerotic heart disease</b>								Indefinite	
DUE TO (c) <b>Hypertensive vascular disease</b>								Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to April 25, 1966, that (I) (we) last saw the deceased alive on April 25, 1966, and that death occurred at <b>HOP.</b> M, from causes and on the date stated above.									
22a. SIGNATURE <i>B. B. Kneisley</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>				22d. ADDRESS <b>148 West Washington Street</b> <b>Hagerstown, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/27/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Hagerstown, Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. RECEIVED BY REGISTRAR <b>APR 29 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06076

## CERTIFICATE OF DEATH

06073

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 50 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1122 Moler Ave.		d. STREET ADDRESS 1122 Moler Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First HARRY Middle RICHARD Last SEIBERT, SR.		4. DATE OF DEATH April 25 1966	
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 7, 1906 59 yrs.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY realestate-ins.	11. BIRTHPLACE (County & State, or foreign country) Dry Run, Md.
13. FATHER'S NAME Richard Seibert		14. MOTHER'S MAIDEN NAME Lelia Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-05-8271	17. INFORMANT Mrs. Helen W. Moser Hagerstown Md Address
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. DATE OF INJURY	
21. I certify that (I) (this hospital) attended the deceased from May 1947, to April 25, 1966 that (I) (we) last saw the deceased alive on April 25, 1966, and that death occurred at 61 M. from causes and on the date stated above.			
22a. SIGNATURE Edward W. Babb, M.D. Ret. Surgeon		22b. DATE SIGNED April 26-66	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Pot St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/28/66	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery
23d. LOCATION (City or Town) (County) (State) rural Clear Spring Md.		23e. ADDRESS	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME		25a. REC'D BY REGISTRAR APR 29 1966	25b. REGISTRAR'S SIGNATURE Charles Juge



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06074

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M		06077										06074	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY		a. STATE											
Washington		Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY											
Hagerstown, Md.		Washington											
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
13 days		Big Spring, Md.											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS											
Washington Co. Hospital		Rural											
e. IS RESIDENCE ON A FARM?													
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
79		3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
		Clara		Elizebeth	Sharon	April		21, 19	66				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER 1 YEAR		11. OVER 24 HRS.	
Female		White		WIOOWEO <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 22, 1904		61 yrs.		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Home duties		House work		McCoys Ferry		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address									
William Patton		Minnie Ward		John Sharon Rd. 4, Hagerstown, Md.									
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
No		None		None		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS		5 mins.					
466x		DUE TO (b) RIGHT PHLEBOTHROMBOSIS		3 days									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c)											
20a. ACCIDENT WAS UNOVERTLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 9, 1966, to April 21, 1966, that (I) (we) last saw the deceased alive on April 21, 1966, and that death occurred at 2:15 PM, from the causes and on the date stated above.		22a. SIGNATURE <i>John H. Kenne</i>		22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input type="checkbox"/> M.E. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS									
JOHN H. KENNE, MD.				1229 Ravenwood Hts., Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/25/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)							
Burial				Green Spring Furnace		Wash. Co. Md.							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Margaret Rowland				APR 26 1966		<i>Charles Judge</i>							

41214

41214

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06078

## CERTIFICATE OF DEATH

06075

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then loose remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or embalming, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN lb 1½ month	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 1459 Potomac Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HILDEGARDE Middle KINGSBURY SHEA	Last	4. DATE OF DEATH April 20	Month Day Year 19 66
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/22/25
9. AGE (In years last birthday) 40 yrs.		10a. US OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	10b. KIND OF BUSINESS OR INDUSTRY space electron.
		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.	
13. FATHER'S NAME John K. Wheeler Sr.		14. MOTHER'S MAIDEN NAME Wilba Hummel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-20-2963 17. INFORMANT Mrs. Wilba Wheeler Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma to brain</i>		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1918</i>			
(b) DUE TO <i>Squamous cell carcinoma of larynx</i>		9 mos	
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <i>Mar 29, 1965</i> , to <i>20 April, 1966</i> , that (I) (we) last saw the deceased alive on <i>7-20-1965</i> , and that death occurred at <i>Hospital</i> M, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>Harold H. Gist</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>22 April 1966</i>
22c. PHYSICIAN'S NAME (Type) Harold H. Gist, M. D.		22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE THEREOF <i>4/23/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Pine Grove Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Berwick, Pa.</i>
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME Hagerstown, Md.		25a. REC'D BY REGISTRAR <i>APR 25 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06079

CERTIFICATE OF DEATH  
06076

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)			
				a. STATE	Maryland	b. COUNTY	Washington
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
Hagerstown		12 hrs.		Sharpsburg		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Washington County Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
3. NAME OF DECEASED (Type or print)		First Dr. Walter	Middle Hal	Last Shealy	4. DATE OF DEATH	Month April	Day 15 Year 1966
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1897	9. AGE (in years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS Days 13 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY General Practice		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Walter K. Shealy		14. MOTHER'S MAIDEN NAME Addie Paget					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. World War #1 215 44 9878		17. INFORMANT Joseph Shealy		Address 116 Lee Ave. Takoma Park Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4201 DUE TO- Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of left ventricle DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 11 1/2 hours 5 min ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes -							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
p.m. 19							
21. I certify that (I) (this hospital) attended the deceased from 4-15 1966, to 4-15, 1966, that (I) (we) last saw the deceased alive on 4-15 1966, and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE John Hornbaker 22b. DATE SIGNED 4-16-66							
22c. PHYSICIAN'S NAME (Type) Dr. John Hornbaker		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 151 W. Washington St. Sykesville Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 19-66		23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Sharpsburg Maryland	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				DATE APR 19 1966		Charles Judge	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

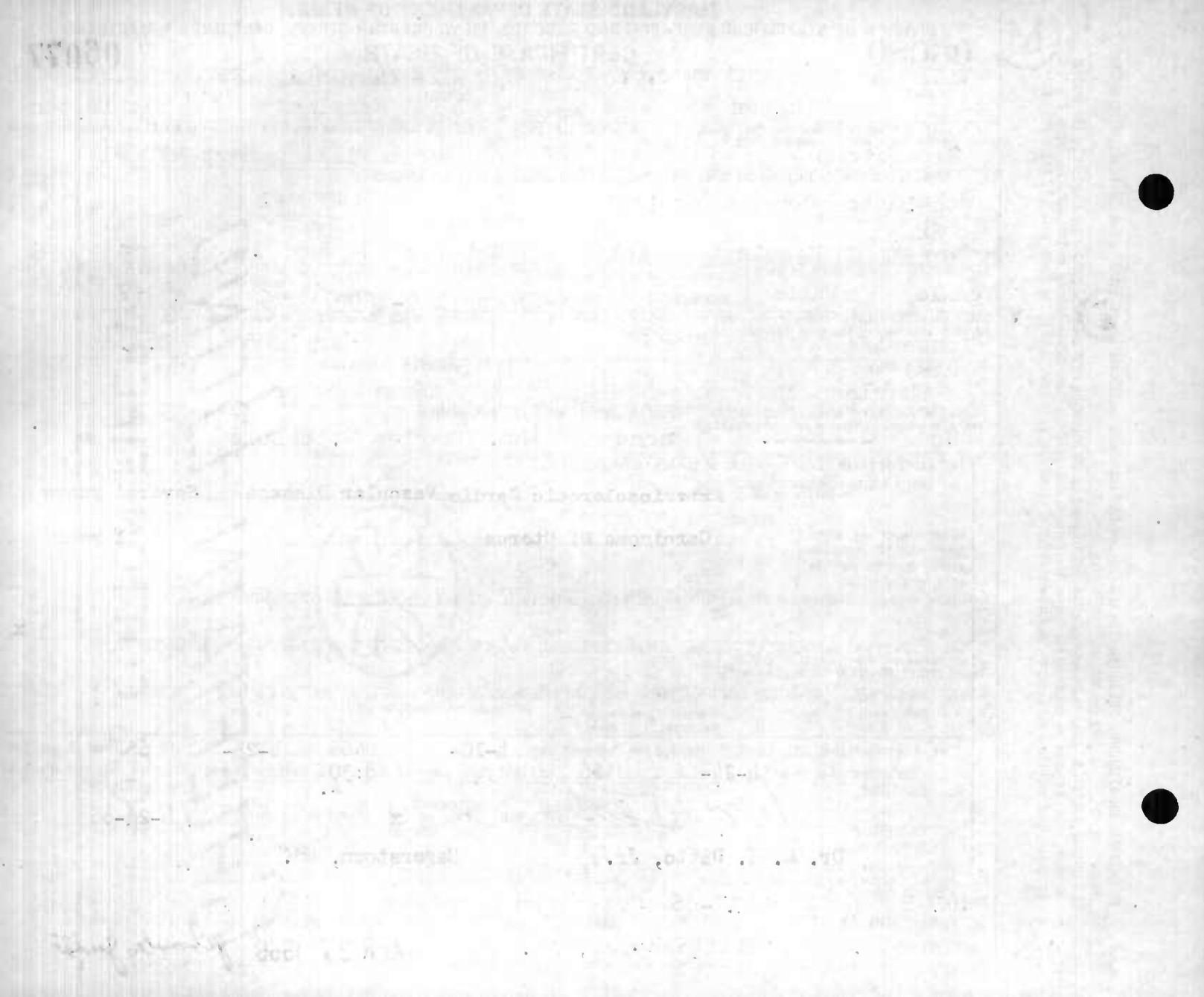
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

Items 5, 6, 7 Film 0376 4/29/66

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Washington MARYLAND		a. STATE Maryland	b. COUNTY Washington
b. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Hagerstown		4 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
Washington County Hospital		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Nannie	Middle Viola	Last Shipley
4. DATE OF DEATH	Month April	Day 29	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 9-1890
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Rupp		14. MOTHER'S MAIDEN NAME Emma Gruber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Charles H. Shipley		Address Williamsport Md. RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease Several years			
4221 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Of Uterus 1 year			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-10-, 1966, to 4-25-, 1966, that (I) (we) last saw the deceased alive on 4-24- 1966, and that death occurred at 8:30M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. E. W. Ditto, Jr.		A. 22b. DATE SIGNED 4-26-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 28-66	
23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) Williamsport Maryland	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.		ADDRESS	
25a. REC'D BY REGISTRAR APR 27 1966		25b. REGISTRAR'S SIGNATURE Charles Juge	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06081

## CERTIFICATE OF DEATH

116078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.		PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		
a. COUNTY		a. STATE		b. COUNTY		
Washington		Maryland		Washington		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		
Hagerstown		2 Months		Rohrersville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
Western Maryland State Hospital				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
91						
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	
		<i>Cora</i>	<i>Moy</i>	<i>SMITH</i>	<i>APRIL 16 1966</i>	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	
<i>F</i>		<i>W</i>	<input checked="" type="checkbox"/> WIOOWEO <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>3/18/80</i>	<i>85 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		
Housewife		Own Home		Rohrersville, Md.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
John Neild		Susan Stine		U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address		
No.		213-48-4207		Mr. Guy L. Smith, Rohrersville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>CORONARY PNEUMONIA</i>				
4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		OUE TO (b)	<i>CORONARY OCCLUSION</i>			
		OUE TO (c)	<i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>YEARS</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW/INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)				
FRACTURE		<i>PT. HEP</i>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)	
19						
21. I certify that (I) (this hospital) attended the deceased from <i>2-23</i> , 19 <i>66</i> , to <i>4-16</i> - 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4-16</i> - 19 <i>66</i> , and that death occurred at <i>1143</i> M, from the causes and on the date stated above.		22b. DATE SIGNED				
22a. SIGNATURE		<i>Eileen A. Ramirez</i>				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	23d. LOCATION (City, town or county) (State)			
<i>Eileen A. Ramirez</i>		<i>1500 PENN. AVE. HAGERSTOWN, MARYLAND</i>	<i>Rural Rohrersville, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)	
Burial		4- 20- 66	Locust Grove Cemetery		Rural Rohrersville, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				APR 21 1966	<i>Charles Judge</i>	

Journal

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE								
WASHINGTON MARYLAND				MARYLAND								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY								
RURAL HAGERSTOWN				WASHINGTON								
c. LENGTH OF STAY IN 1b				21-1								
5 DAYS												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE DN A FARM?								
AVALON MANOR INC.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month	Day	Year			
MARY		LITTLE	STICKELL	APRIL		3	19	66				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
FEMALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DEC. 24, 1886		79 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY
HOMEMAKER				OWN HOME				WASHINGTON CO., MARYLAND				U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME								
HENRY ZEIGLER				ALICE LITTLE								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		HAGERSTOWN, MD.						
NO		-----		MR. HOWARD STICKELL		209 MEALEY PKWY.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma to lungs.												7 mo
180X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) carcinoma of kidney												1 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CNDTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
19												
21. I certify that (I) (the hospital) attended the deceased from Mar. 1966, to Apr. 3 1966, that (I) (we) last saw the deceased alive on April 3 1966, and that death occurred at 2 P.M. from the causes and on the date stated above.												
22a. SIGNATURE												22b. DATE SIGNED
Phyllis G. Hoffman												4/4/1966
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS								
LLOYD A. HOFFMAN M.D.				214 N. POTOMAC ST. HAGERSTOWN, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City, town or county)				(State)
BURIAL		APRIL 6, 1966		ROSE HILL CEMETERY				HAGERSTOWN, MARYLAND				
24. FUNERAL DIRECTOR		ADDRESS								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Charles M. Renger		HAGERSTOWN, MARYLAND								APR 11 1966		Charles Judge
VR A15 (4) 20M 1/65												

Digitized by srujanika@gmail.com

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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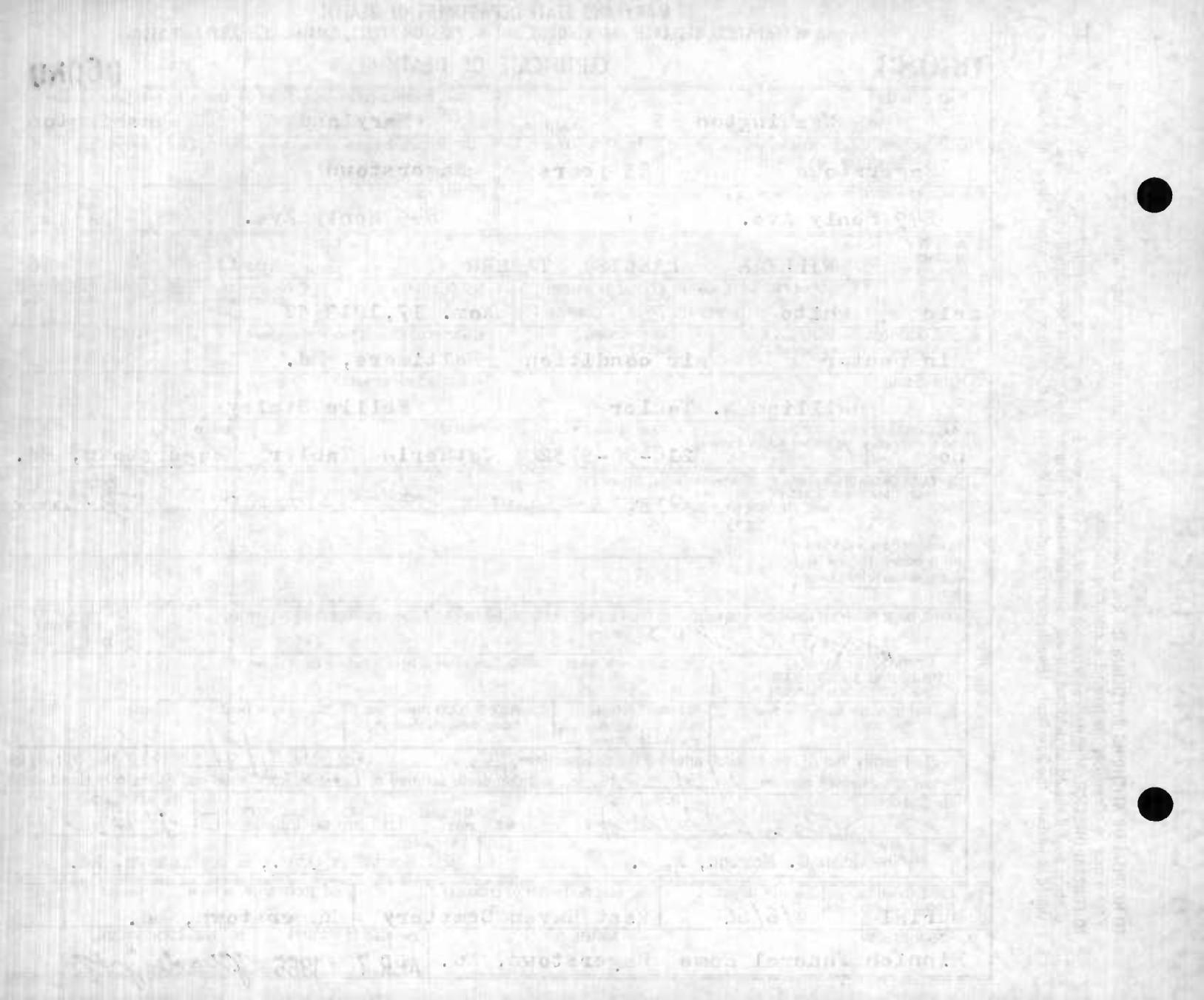
06083

## CERTIFICATE OF DEATH

06083

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician.  
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>35 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>849 Kenly Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>849 Kenly Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>LANDIS</b>	Last <b>TABLER</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1913</b>
9. AGE (In years at last birthday) <b>52</b>	10. KIND OF BUSINESS OR INDUSTRY <b>air condition</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>William A. Tabler</b>	14. MOTHER'S MAIDEN NAME <b>Nellie Staley</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>218-30-9752</b>		17. INFORMANT <b>Catherine Tabler</b>	Address <b>Hagerstown, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>3 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Hypertension</i>			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>580 Northern Ave., Hagerstown, Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 17, 1966</b> , to <b>4/1/66</b> , that (I) (we) last saw the deceased alive on <b>4/3/1966</b> , and that death occurred at <b>12 M.</b> from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>John C. Morton</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4/1/66</i>
22c. PHYSICIAN'S NAME (Type) <b>John C. Morton, M. D.</b>		22d. ADDRESS <b>580 Northern Ave., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>4/6/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>	ADDRESS <b>Hagerstown, Md.</b>	25a. REC'D BY REGISTRAR <b>APR 7 1966</b>	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06084

## CERTIFICATE OF DEATH

06081

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and again event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital 79		d. STREET ADDRESS 820 Potomac Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARRY	Middle IRA	Last THOMAS
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 28, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY Leather Mfa.	11. BIRTHPLACE (County & State, or foreign country) Indiana, Penna.
13. FATHER'S NAME Lewis Thomas		14. MOTHER'S MAIDEN NAME Mary F. Fleming	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-0947	17. INFORMANT Mrs. Ruth Custer Address Hagerstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2001 DUE TO <i>Brechloigenic Carcinoma c Metastasis generalised</i> 2 yr		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Small Cell lymphosarcoma</i> 1 yr (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. 19 of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/13, 1966, to 4/22, 1966, that (I) (we) last saw the deceased alive on 4/22 1966, and that death occurred at 1245PM, from causes and on the date stated above.		22b. DATE SIGNED 4/22/66	
22o. SIGNATURE Robert W Campbell M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Robert Campbell		22d. ADDRESS Hagerstown Md.	
23o. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/25/66	23c. NAME OF CEMETERY OR CREMATORIALy Rose Hill Cemetery
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME		ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR APR 26 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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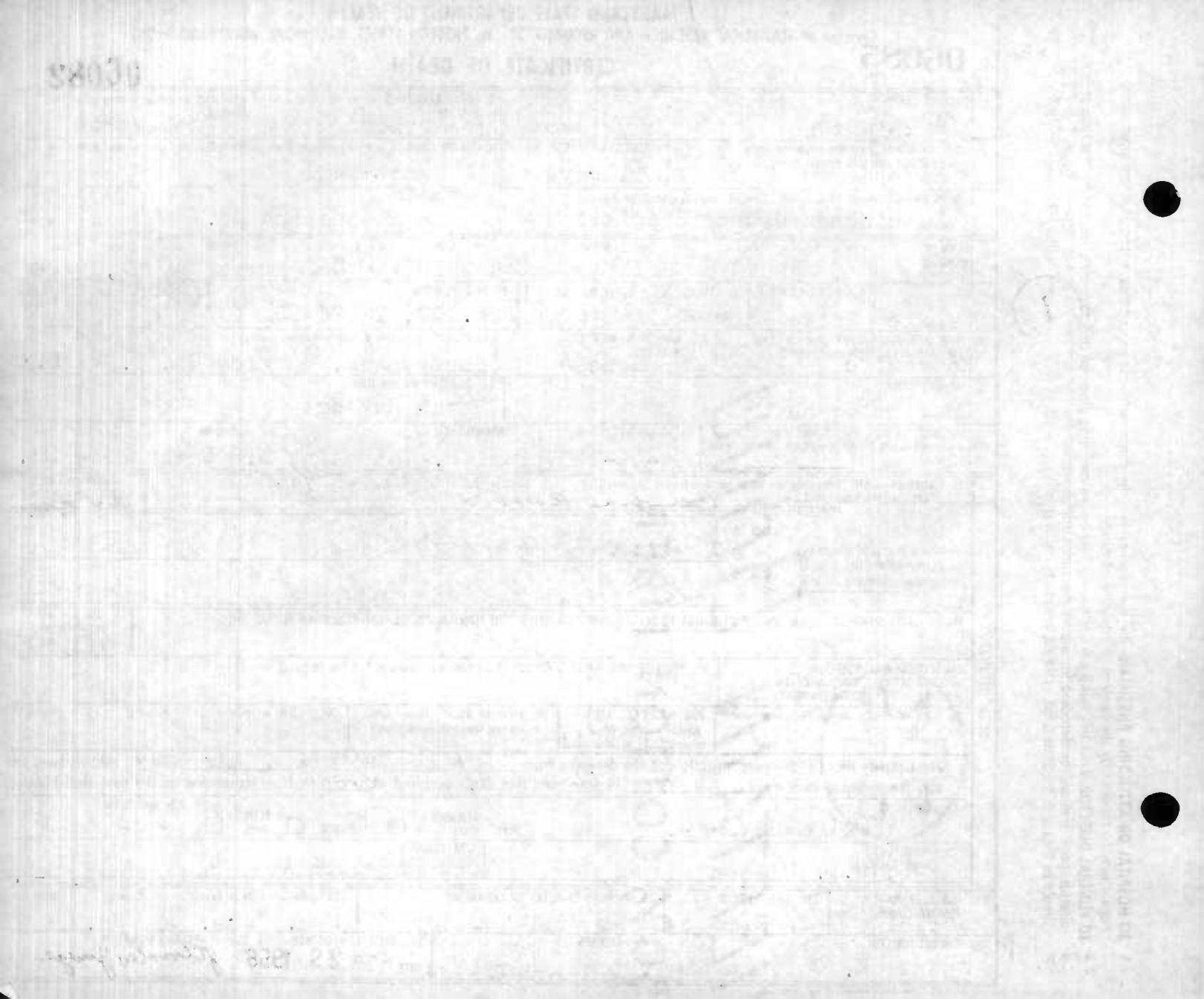
## CERTIFICATE OF DEATH

06082

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>11 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>318 Devonshire Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>RUTH REBECCA VALENTINE</b>		First <b>RUTH</b>	Middle <b>REBECCA</b>
3. NAME OF DECEASED (Type or print) <b>RUTH REBECCA VALENTINE</b>		Last <b>VALENTINE</b>	4. DATE OF DEATH Month <b>April</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9. BIRTHDATE (In years last birthday) <b>Feb. 23, 1897</b> 69 yrs.	
10. JOB. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cherry Run, Berkley Co., W. Va USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Crane</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Harper</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>314-09-9057</b>		17. INFORMANT <b>Paul R. Valentine 318 Devonshire Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address <b>Hagerstown, Maryland</b>	
4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
DUE TO (b)		DUE TO <b>Congestive Heart Failure</b>	
DUE TO (c)		DUE TO <b>Generalized Atherosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> , to <b>27 Apr 1966</b> , that (I) (we) last saw the deceased alive on <b>26 Apr 1966</b> , and that death occurred at <b>6:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>J.D. Wilson</b>		22b. DATE SIGNED <b>4/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J.D. Wilson</b>		22d. ADDRESS <b>580 Northern Ave., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/29/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hag. Wash. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Hagerstown, Maryland</b>		25a. REC'D BY REGISTRAR <b>A-R 29 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Resided before admission)										
a. COUNTY <b>Washington</b>				a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>														
3. NAME OF DECEASED (Type or print) <b>Edna Grace Genieva Van Metre</b>				First	Middle	Last	4. DATE OF DEATH <b>April 2 1966</b>	Month	Day	Year				
5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1916</b>	9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Martinsburg, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles John Snyder</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle Kendrick</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>232-26-6597</b>				17. INFORMANT <b>Mrs. Charlotte Ridenour</b>				Address <b>Chewsville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b>														
416X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b>														
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>M</b>	(County) <b>Booneboro</b>	(State) <b>Rural</b>
21. I certify that (I) (this hospital) attended the deceased from <b>2-25</b> , 19 <b>66</b> , to <b>4-2-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-2</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>Charles C. Spencer</b>				22b. DATE SIGNED <b>APR 7 1966</b>										
22c. PHYSICIAN'S NAME (Type) <b>Charles C. Spencer, M. D.</b>				22d. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/5/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Hagerstown Md.</b>		
24. FUNERAL DIRECTOR <b>W. C. Harst</b>				ADDRESS <b>Rest Haven Funeral Chapel Hagerstown, Md.</b>								25a. REC'D BY REGISTRAR <b>APR 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

• 6. *Technique* • *See also* *Conventions*

*toothed* *shrub*

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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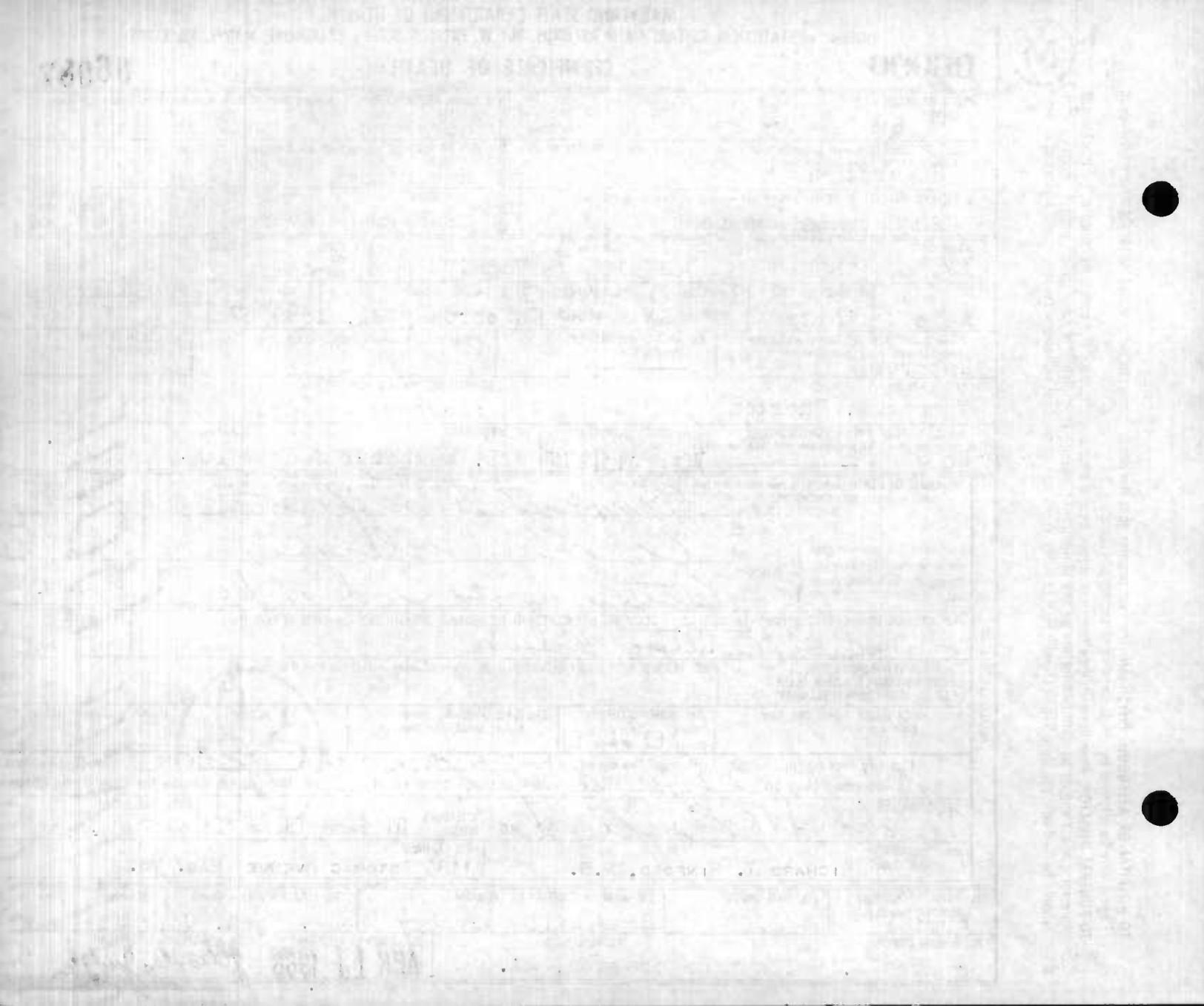
## CERTIFICATE OF DEATH

06087

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>28 Harmans Avenue</b>		d. STREET ADDRESS <b>28 Harmans Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS</b>		First <b>BENTON</b>	Middle <b>WHORTON</b>
4. DATE OF DEATH <b>April 3, 1899</b>	Month	Day	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>February 21, 1899</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (County & State, or foreign country)	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Thomas B. Whorton</b>		14. MOTHER'S MAIDEN NAME <b>Florence Bussard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-9275</b>	17. INFORMANT <b>Mrs. Margaret Houser</b>
		Address <b>1024 Corbett's</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>1-3 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <b>Congestive heart failure</b> years last. (c) DUE TO <b>Arteriosclerotic Cardio-De.</b> years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia, Cardiac Failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>date</b>
20f. (City or town) <b>date</b>		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>25 June, 1956</b> , to <b>date</b> , 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>23 Feb 1966</b> , and that death occurred at <b>date</b> M, fram causes and an the date stated above.			
22a. SIGNATURE <b>Richard T. Binford, M.D.</b>		M.D. ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4 April 56</b>
22c. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b>		22d. ADDRESS <b>1135 POTOMAC AVENUE HAG. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Rose Hill Cemetery</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Hagerstown, Md.</b>		25a. RECEIVED BY REGISTRAR <b>11 1 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judd</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06087

## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R # 5 (Fiddlersburg)		d. STREET ADDRESS R # 5 (Fiddlelersburg) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence First Albert Last Williams		4. DATE OF DEATH Month Day Year April 25 1966	
5. SEX Male White		6. COLOR DR RACE WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> OIVORCEO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1878	
9. AGE (in years last birthday) 87 yrs.		10. KIND OF BUSINESS OR INDUSTRY Stationary Engineer Power Plant	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Riley Williams		14. MOTHER'S MAIDEN NAME Mary Elizabeth McCarty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-18-8752 17. INFIRMITY Mr. F.E. Williams 703 Antietam St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 <i>arteriosclerosis heart disease</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>due to</i> (b) <i>Pneumonia</i> 4-14-66 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 14</i> , 1966, to <i>April 25</i> , 1966, that (I) (we) last saw the deceased alive on <i>April 22</i> , 1966, and that death occurred at <i>Hagerstown</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Sidney Novenstein</i>		22b. DATE SIGNED 4-26-66	
22c. PHYSICIAN'S NAME (Type) <i>SIDNEY NOVENSTEIN</i>		22d. ADDRESS <i>Funks town MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>#28/66</i> 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Rest Haven Cemetery</i>	
24. FUNERAL DIRECTOR <i>Wiley G. Ross</i>		23d. LOCATION (City, town or county) <i>Hagerstown</i> (State) <i>Md.</i>	
25a. REC'D BY REGISTRAR <i>APR 28 1966</i> DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
Hagerstown		3 Days		Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Western Maryland State Hospital		323 Holland Street			
3. NAME OF DECEASED (Type or print)		First DESSIE	Middle MARY	Last WILLIAMS	4. DATE OF DEATH APRIL 28 1966
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1888	9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME Charles E. Cherry		14. MOTHER'S MAIDEN NAME Martha Dugan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-6009		17. INFORMANT Miss Jane C. Williams, 323 Holland St. Cumb'd Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		CORONARY THROMBOSIS ACUTE 4 HOURS			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) GENERALIZED ATHEROSCLEROSIS UNKNOWN	OUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSION					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 4-25-1966, to 4-28-1966, that (I) (we) last saw the deceased alive on 4-28-1966, and that death occurred at 10 AM, from the causes and on the date stated above.					
22a. SIGNATURE ANTONIO U. PALLAROS		22b. DATE SIGNED 4-28-66			
22c. PHYSICIAN'S NAME (Type) Antonio U. Pallaros		22d. ADDRESS 1500 PENN AVE HAGERSTOWN			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 1, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City, town or county) (State) Cumberland Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR MAY 2 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
John J. Hafer		230 Baltimore Ave. Cumberland Md.			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06089

## CERTIFICATE OF DEATH

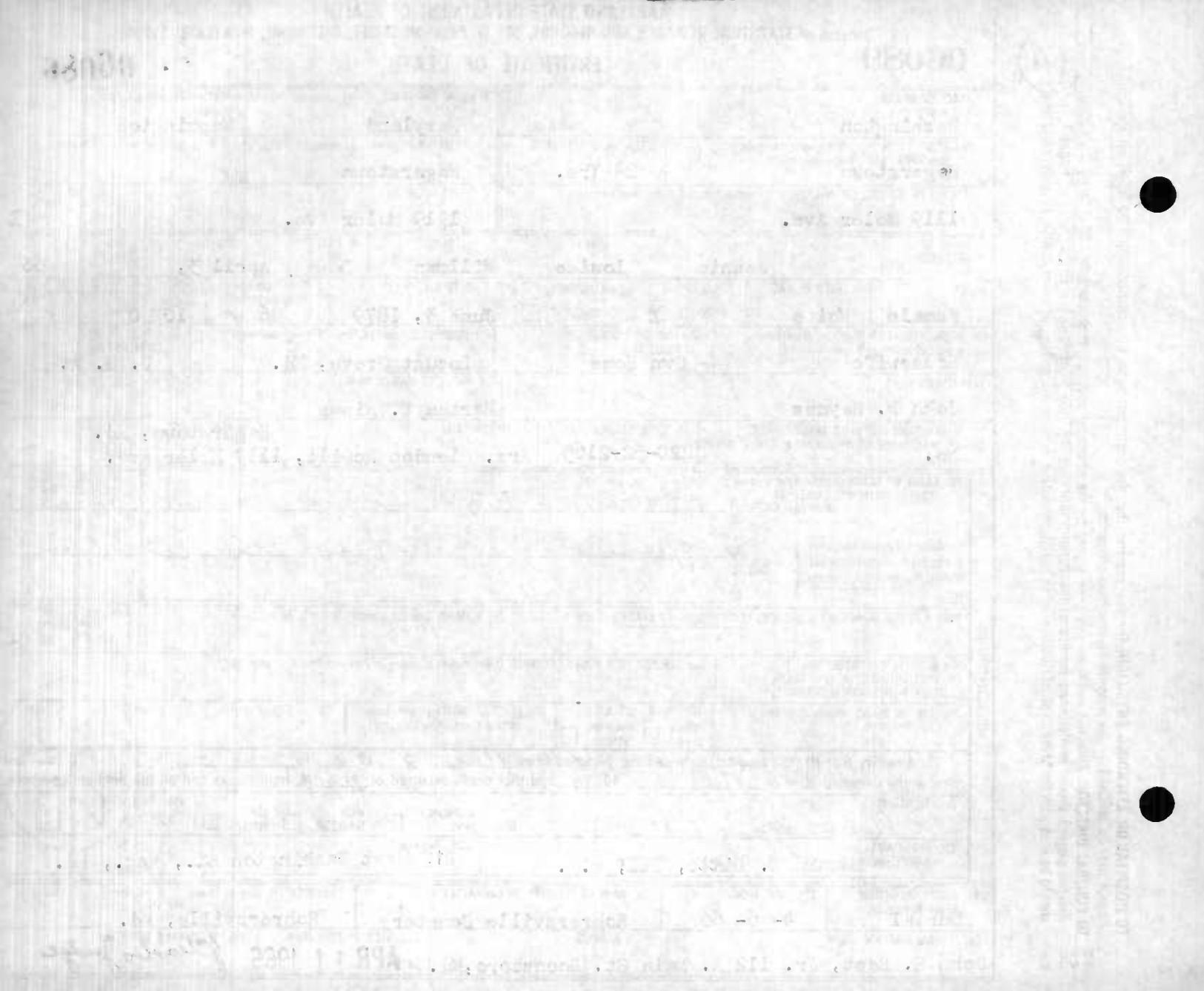
06086

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>24 Yrs.</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1119 Moler Ave.</b>				d. STREET ADDRESS <b>1119 Moler Ave.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First <b>Jennie</b>	Middle <b>Louise</b>	Last <b>Willman</b>	4. DATE OF DEATH <b>April 3,</b>	Month <b>1966</b>	Day <b>19</b>	Year <b>66</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1879</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months <b>10</b>	IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Locust Grove, Md.</b>		
13. FATHER'S NAME <b>John W. Haynes</b>				14. MOTHER'S MAIDEN NAME <b>Martha E. Hines</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>220-52-2165</b>		17. INFORMANT <b>Hagerstown, Md.</b> <b>Mrs. Glendon McGill, 1119 Moler Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>4200</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO <b>20 yrs</b> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 22, 1966</b> , to <b>Apr 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>Apr 2, 1966</b> , and that death occurred at <b>Hagerstown, Md.</b> from causes and on the date stated above.								
22a. SIGNATURE <b>Edward W. Ditto, III, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto, III, M.D.</b>		22d. ADDRESS <b>217 West Washington St., Hagerstown, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rohrersville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rohrersville, Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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06091

## CERTIFICATE OF DEATH

06088

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAY KENDALL WINE</b>		First <b>Ray</b>	Middle <b>KENDALL</b>
4. DATE OF DEATH <b>April 27, 1966</b>		Month <b>April</b>	Doy <b>7</b>
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>Mar. 29, 1899</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>airplane mfg.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Shenandoah, Co., Va.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Bertie Fleming</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-03-3644</b>	
17. INFORMANT <b>Mrs. Harry Harpine</b>		Address <b>New Market, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Congestive heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Twice</b>	
4200 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause <b>Arterio sclerotic heart disease</b>		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Hypertension - Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Timberville</b>
20f. (City or town) <b>Timberville</b>		(County) <b>Va.</b>	
(State) <b>VA</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>28 March 1966</b> , to <b>1 April 1966</b> , that (I) (we) last saw the deceased alive on <b>6 Mar 1966</b> , and that death occurred at <b>1 PM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>4/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. L. E. H. Hoachlander</b>		M.D. <b>Hoachlander</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <b>Flat Rock Cemetery</b>		22d. ADDRESS <b>Timberville, Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/9/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Flat Rock Cemetery</b>
23d. LOCATION (City or Town) <b>Timberville</b>		(County) <b>VA</b>	
(State) <b>VA</b>			
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		ADDRESS <b>Hagerstown, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>APR 11 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06092

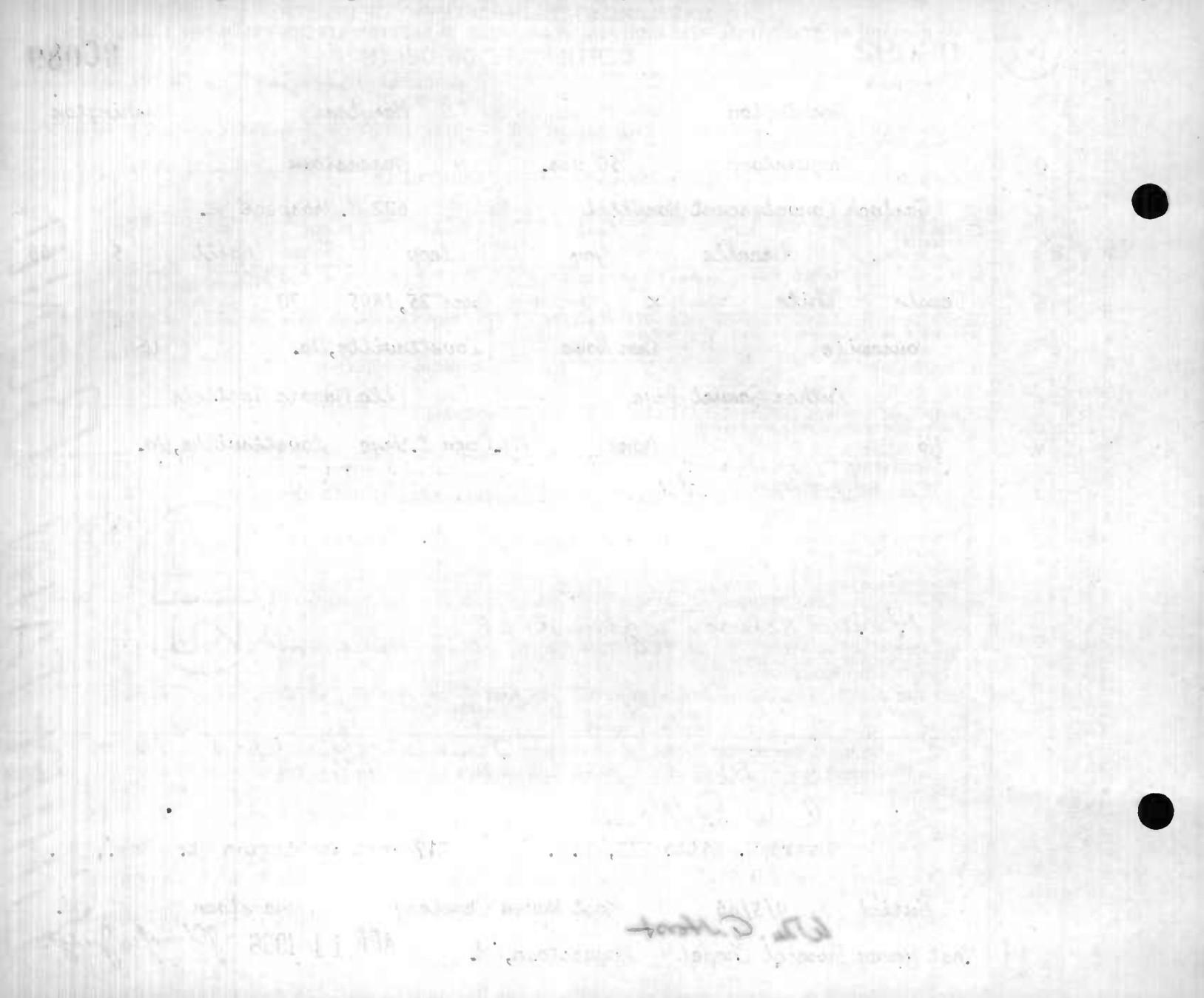
CERTIFICATE OF DEATH

116089

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)	
a. COUNTY <b>Washington</b>		a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Convalescent Hospital</b>		d. STREET ADDRESS <b>622 N. Prospect St.</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Urelle</b>		First <b>Urelle</b>	Middle <b>Gay</b>
4. DATE OF DEATH <b>April 5 1966</b>		Last <b>Zepp</b>	Month <b>April</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>June 25, 1895</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>70 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Lovettsville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther Samuel Frye</b>		14. MOTHER'S MAIDEN NAME <b>Ella Madora Bartlett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Owen L. Frye</b>		Address <b>Lovettsville, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno carcinoma Breast c</b>			
170X DUE TO			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <b>wide spread metastasis</b>			
DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arterio sclerosis, generalized</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1966</b> , to <b>Apr 5, 1966</b> , that (I) (we) last saw the deceased alive on <b>Apr 5, 1966</b> , and that death occurred at <b>68</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto</b>		22b. DATE SIGNED <b>4-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>217 West Washington St. Hag., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. C. Herst</b>		25a. REC'D BY REGISTRAR DATE <b>APR 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06093

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06093

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN lb <i>50 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>14 East Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edward</i>		First <i>Edward</i>	Middle <i>Black</i>
4. DATE OF DEATH <i>April 10 1966</i>		Lost <i>Zimmerman</i>	Month <i>April</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept. 22, 1903</i>		9. AGE (In years last birthday) <i>62 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>	
11. BIRTHPLACE (State or foreign country) <i>Frederick County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Franklin Zimmerman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Black</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-09-3050</i>	
17. INFORMANT <i>Mrs. E. B. Zimmerman 14 East Ave. Hagerstown, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar Pneumonia, Left Lower Lobe &amp; Right Lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. <i>490X</i> (b) <i>Acute Pleuritis, Left</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>A. E. W. Ditto</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <i>4-11-66</i>			
Address (Street, city, town, or county) <i>Hagerstown, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4/12/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Rest Haven Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Hagerstown Wash. D.C.</i>
24. FUNERAL DIRECTOR <i>W. G. Howett</i>	ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>	25a. REC'D BY REGISTRAR <i>APR 13 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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